A COLLABORATIVE MODEL FOR MINISTRY TO RESIDENTS IN NURSING HOMES

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ABSTRACT

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The context for this project is the Women in Ministry Resource Center in Mitchellville, Maryland. The hypothesis of this project is that the training of nursing home ministry volunteers would improve religious services and visitation programs to residents. The methodology utilized is a combination of qualitative and quantitative research design which includes observations, interviews, surveys, and pre/post tests as methods of data collection. The findings show that perceptions toward serving the elderly improved as a result of training.

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The writer acknowledges God for his faithfulness and grace during this journey. The writer also honors and acknowledges God for strength and energy during this major undertaking. There are many people who were placed in the writer's path during this journey in preparation of this research project. The writer expresses appreciation and gratitude to the many people who encouraged, supported, and gave suggestions during the writing of this project. The writer acknowledges and thanks Dr. Herldleen Russell, Dr. Myron Noble, Dr. Sharon Dunlevy, Dr. Barbara Bryant, and Dr. Estelle Gross for their support encouragement and assistance in this dissertation. In addition, appreciation and thanks to special friends and collaborators, Rev. Charlene McCamey, Hattie Boney Anderson, Dr. Sheila Albright, and Melissa Belt for encouragement, prayers, and faithfulness in telephone calls of support.

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DEDICATION

This project is dedicated to the faithful support of my husband, Fred Harris, my daughter, Angela, and my grandchildren Chauntese and Olandis who encouraged, cheered me on, and assisted in typing and proofreading, and who were always looking for ways to help. Their collaborative efforts were a blessing and a help toward the completion of this project.

INTRODUCTION

The aging and disabled population is living longer and sometimes requires special assistance, which may not always be provided by the family. Nursing homes are places where people reside who are chronically ill and have a medical disability that affects their ability to care for themselves. Some individuals become permanent residents of nursing homes, while other individuals are placed in nursing homes on a temporary basis due to an accident or short–term rehabilitation. Nursing home residents need contact and fellowship, which the church family and their biological family can provide. The Church must give special attention to the spiritual needs of residents in nursing homes. Residents in nursing homes need the assurance and encouragement that a caring community can bring when the challenges of life affect their ability to care for themselves. A ministry to the residents in nursing homes is an opportunity to serve those who are unable to attend a regular church worship service.

Chapter One introduces the reader to the writer's spiritual journey which includes preparation and call to ministry, context for ministry, and collaboration in ministry.

Chapter Two examines the relevant research studies done in the area of serving the elderly and residents in nursing homes.

Chapter Three explores the historical, biblical, and theological foundation for ministry to the aging and disabled in nursing homes.

Chapter Four explains the methodology and design used to collect and measure the data that was used in the field experience.

Chapter Five describes what happened during the field experience and the results.

Chapter Six gives reflections, summaries, and conclusions of the research project with suggestions for future modifications.

CHAPTER ONE

MINISTRY FOCUS

People and experiences shape and influence our lives, and God orders our steps. Looking back, the writer recognizes that God has placed many people in her path to touch her life in some way. Many individuals have raised her spiritual consciousness of God, some have helped shape her character, and others nurtured spiritual development and left indelible marks on her life. As one journeys through life it is not always clear where the path will lead, for we are on divine assignments. God gives us experiences that allow us to express our God–given talents. In this chapter, the writer will describe the people and experiences that have prepared her for ministry.

The formative years of the writer were spent with grandparents and other relatives, who were Christians. Most of the writer's family members were Baptists and attended church regularly. The writer attended church and Sunday School almost every Sunday while living with her grandmother. The writer believes that living with her grandmother greatly impacted her life. There was a sense of worth as the grandmother listened to concerns and encouraged the writer to go to school to get an education. The writer thinks that most grandmothers are attentive to and concerned about the spiritual development of their grandchildren. Even though Bible verses were not quoted, she encouraged and emphasized Godly virtues, which included telling the truth, respecting older people, and doing the right thing. The writer's grandmother was a praying woman

and had a concern about helping others in the community. In hindsight, the writer's grandmother had a great influence on her interest in ministering to the aging.

Although the writer was instilled with some biblical principles at the grandparents' home, she attended church regularly, and sang hymns and recited Bible scriptures in elementary school; she did not become a member of the local church. Even though the writer had exposure to the Christian experience, she did not accept Jesus as Savior until she was a young adult. The writer learned about God, but did not have a clear understanding about having a relationship with Him.

The writer attended Howard University in Washington, D. C. and majored in Sociology earning a B.A. degree. The writer received a fellowship from Howard University to attend graduate school to study Student Personnel Administration where she earned a Masters Degree. The writer had a desire and an interest in helping students make wise career choices affecting their lifestyles and earnings. The writer worked in a university setting with college students for 13 years.

Shortly after graduation from college, the writer's father questioned her about spiritual matters and church. The writer's father encouraged the writer to join and get involved in church. The writer joined a Baptist church and began to sing in the choir. However, she recognized something was missing. The writer was never told there was a need to make a formal commitment and develop a relationship with Jesus.

The writer accepted Christ into her life in 1978 and began to learn and grow in the knowledge and understanding of spiritual things. After accepting Christ, the writer spent most of her time reading the Bible and Christian books. The writer participated in Bible studies and seminars, learning all she could about God. Jesus and the church were the

writer's passion and the missing links in her life. The writer's life was centered around the church, especially encouraging others to come to and join the church.

During this time, the writer joined Ridgley Church of God in Christ, under the leadership of Dr. Herbert Russell, pastor, and his wife Dr. Herldleen Russell. Pastor and Evangelist Russell were role models and had a major influence on the writer. The Russells were caring and compassionate people reaching not only their members, but serving others who were not members of the church. They prayed, visited the sick, and were available for opportunities to serve others. Both were great teachers and preachers; they epitomized the role the Bible describes for church leaders. The ministry of the Russells influenced the writer in her spiritual growth and development for ministry.

Under the leadership of the Russells at Ridgley, the writer was appointed to the position of Youth Director. As Youth Director, the writer had freedom and flexibility to create programs and activities that would keep the youth interested in church as well as develop Christian character. Also, the writer served as the Church Clerk and Financial Secretary.

Additionally, the writer was employed in several secular positions where she gained experience in administration, management, teaching, counseling, planning, and training. The author had opportunities to grow and develop her skills, abilities, and talents because there was freedom and flexibility in her employment. Almost every position in which the writer worked was useful for serving in ministry and serving others. The writer worked at several colleges and universities prior to serving in the church and volunteered in several outreach ministries.

In 1983, the writer felt called to the Christian bookstore ministry and opened a Christian bookstore in 1984. This calling fulfilled two passions, a great love for reading, particularly Christian literature, and a desire to have a business. The bookstore ministry was a work of faith that increased and strengthened the writer's prayer life. The bookstore was just as much ministry as it was business. People called or came to the bookstore for prayer. The bookstore was a place where people accepted Christ as Savior and a place where people could come to get an encouraging word and answers to Bible questions.

While serving in the bookstore, the writer felt called to ministry as an Evangelist in September 1985. The writer did not acknowledge the call immediately because of a lack of confidence and anxiety of public speaking. The writer had always been shy and reserved; however, the writer sought her pastor and began ministerial training in her local church. Shortly after beginning the training the writer married, changed church membership, and placed ministry preparation and plans on hold. It is the writer's belief that ministry begins at home; and the home must be in order before reaching out to serve others. The writer's husband and family have always been supportive of the writer's involvement in ministry. The writer and her husband were ordained as deacons in their local church, Evangel Cathedral, and served in church ministries together. During this time, the writer attended Regent University and took some courses in ministry with an emphasis in practical theology. The responsibilities of family, business, and challenges of life limited the writer's ability to move forward in ministry.

God has a way of getting one's attention when it is time to move in another direction. The writer began to feel spiritually and physically burned out due to the pace

and responsibilities of the business. The bookstore ministry became more challenging with time. The writer believes that this was God's way of moving her on to another assignment.

After closing the bookstore, the writer began to wait on the Lord for directions, thinking that closure of the bookstore ministry would make her available and give her clarity for the next move. The writer began to get involved in ministries at her local church, which included facilitating a Bible Study for new members and teaching in the Bible School. In addition, the writer worked with a local community ministry, the Association for Full Gospel Women Clergy, as their Director for Ministry Resources. In 2004, the writer coordinated the publication of a devotional book to be used in fundraising. Then in December 2006, the writer joined Zion Church, and in 2007, she became the Coordinator of a ministry to senior assisted living facilities, which includes Peaceful Life and Rose's Place Inc. The Senior Assisted Living Ministry is a part of the Evangelism and Outreach.

The calling to serve the hurting and lost is confirmed through the love and concern for people. The writer's compassion for people has developed out a life of suffering and struggles. Compassion creates sensitivity toward the needs and concerns of others. It gives us an understanding of how to help and comfort people. There are many lessons to learn from life and the experiences of life. Failures help you recognize the areas that need improvement and ways to do things better. Failures also lead you to draw closer to God and seek Him for clarification, guidance, and instructions. The successes of life help you recognize your strengths, gifts, and the blessings of God.

Over the years the spiritual development has caused the writer to evolve from timidity to boldness particularly in areas of witnessing and talking to people about God, salvation, and righteous living. God has blessed the writer with several spiritual gifts, including administration, exhortation, mercy, teaching, and evangelism. These gifts have been utilized in serving in the church as well as the community. Almost every position in which the writer worked has been helpful in developing serving skills, which are useful in ministry and serving others.

For example in August 2002, the writer established a Resource Center for Women. The Ministry Resource was originally developed out of a need to provide information on tools and techniques for effective ministry for women who were trying to find their place in ministry and to promote excellence in ministry. The ministry has evolved to offer community outreach opportunities and referral services. The Resource Center has developed a collaborative relationship with other ministries.

The writer's interest for this project has grown out of a desire to fulfill God's calling to minister to other women who struggle with a call to ministry. Therefore, it was the plan of the writer to help women develop excellent skills in leadership as they serve the church, and advance the kingdom of God utilizing their talents and spiritual gifts. The context for this project grew out of a concern for the many social issues that plague the local community and the lack of outreach by local churches. The Women's Ministry Resource Center was established in Prince George's County in August 2002 to address some of the social problems affecting the local community and to provide women laity an opportunity to do ministry in the local community. The writer has always had a passion and concern for helping others through providing information, counseling, and referrals

to other people or sources. After visiting with the elderly and serving a ministry to the disabled in nursing homes the writer developed a compassion for the aging and disabled. The writer discovered that many aging relatives, church members, and individuals without family or children do not have significant others to visit them.

The mission of the Resource Center is to mobilize a network of women ministers to impact and transform the local community for Christ through collaborative efforts. Men are invited and encouraged to assist and participate. One area of service provided by the Ministry Resource Center is ministry in nursing homes and other long–term care facilities. However, for the purposes of this research, the Ministry Resource Center's focus is to develop a collaborative program for ministry to the elderly in nursing homes. The five areas of the Ministry Resource Center are listed as:

1. Equipping laity to do ministry in the local community,
2. Providing resources and tools for effective ministry,
3. Assisting in improving leadership skill through mentoring, coaching, and training,
4. Providing opportunities for ministry through local community programs, and
5. Collaborating with other ministries and community organizations.

Context for Ministry

The context for this project is the Ministry Resource Center, a Christian community outreach ministry located in Mitchellville, Maryland. The center is a network of women working to serve the spiritual needs of those in long-term care facilities. The ministry is coordinated by the writer and six lay volunteers, and one licensed minister. The volunteers are from several churches. Some of the churches do not have a ministry to the elderly. Most of the volunteers are over fifty years old. The ministry has worked in

collaboration with two local churches and partnered with another local ministry. The Ministry Resource Center is located in Mitchellville, Maryland, a town with a population of 9,611 located in Prince George's County.[1] Prince George's County is a suburb of Washington, D.C., the nation's capitol and bordered on the southwest by the state of Virginia. It is considered a part of the greater Metropolitan Washington area, which includes suburban areas of Maryland, Virginia, and the District of Columbia.

Prince George's County has become a place of unparalleled diversity. The nearly 850,000 residents are of every ethnic, racial, and religious background. In the 495 square miles, one can hear more than 100 languages spoken by people who have come from every corner of the world.[2]

As of the estimated census of 2004, there were 842,967 people, 286,610 households, and 198,047 families residing in the county. There are 308,929 housing units. The racial make–up of the county was 62.70% African Americans, 27.04% White, 7.12% Hispanic or Latinos, 0.35% Native Americans, 3.8% Asians, 0.06% and 3.38% from other races.[3]

There are 286,610 households out of which 35.30% had children under the age of 18 living with them, forty-five percent were married couples living together; 19.60% had a female household with no husband present, 3.90% were singles, 24.10% of all households were made up of individuals, and 4.90% had some one living alone who was

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[1] "Maryland Bigger Cities," available at http://www.city–data.com/city/Maryland.html, accessed October 10, 2007.

[2] "Prince George's County, Maryland, 2006," available at http:/www.wikipedia.org, accessed June 8, 2006.

[3] "Prince Georgian Cares, 2002," available at http://www.pgcares.com, accessed June 8, 2006.

65 years of age or older. The average household size was 2.74 persons, and the average family size 3.25 persons.[4]

The county's population was spread out with 26.80% under the age of 18, 10.40% from 18 to 24, 33% from 25–44, 22.10% from 45–64, and 7.70% who were 65 years of age or older. The median age was 33 years and for every 100 females there were 91.50 males. For every 100 females age 18 and over, there were 87.20 males.[5]

As of 2004, the median income for a household in the county was $55,256, and the median income for a family was $62,467. Males had a median income of $38,904 versus $35,718 for females. The per capita income for the county was $23,360. Almost eight percent of the population and over five percent of families were below the poverty line. Nine percent of those under the age of 18 and almost seven percent of those 65 and older were living below the poverty line. Prince George's County is the most affluent county with an African American majority in the United States.[6]

Prince George's County is the home to over 800 churches as well as a number of mosques, synagogues, and Hindu temples.[7] Most of the churches in the county are Christian. Property belonging to religious entities makes up 3,450 acres. The religious climate in Prince George's County reflects the diversity of its population. There are many denominations within the county. The top five denominations in size and number include

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[4] "Prince George's County, Maryland, 2006."

[5] Ibid.

[6] Ibid.

[7] Ibid.

Southern Baptists, United Methodist, Roman Catholic, American Baptist, and the Episcopal Church.[8]

Over the last decade, there has been a tremendous growth in churches in the county and many with member attendance over 2000 on Sundays. These churches with such growth are called megachurches. In as much as the Prince George's County population is majority African American, most of the megachurches are African American. The Church has been the center and source of social and economic life for African Americans and has offered opportunity for worship and programs to minister to their spiritual and social needs. Out of the 800 churches in Prince George's County, there are 14 churches listed as megachurches with church membership totals of 3,000 to 19,000 and with an average weekly attendance of 2,000–7,500.[9]

Many churches moved from Washington, D.C. in the 1990s to Prince George's County because of the vast amount of land for building and parking. Many of the church members were already living in the county. In addition to meeting in regular church buildings, many churches meet and worship in schools, shopping centers, county libraries, and homes.

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[8] *The Association of Religion Data Archives*, "County Membership Report: Prince George's County, Maryland, 2000," available at http://www.thearda.org/mapReports/counties/24033_2000.asp, accessed June 6, 2006.

[9] Scott Thumma, *Hartford Institute for Religion Research*, "Megachurches Databases," available at http://hirr/hartsem.edu/megachurch/megastoday2005_profile.html, accessed June 6, 2006.

There are 61,951 people in the county who are 65 and over.[10] There are 21 licensed nursing homes in Prince George's County that care for 2,155 residents.[11]

Statement of the Problem

The church is active in the county; however, there are many needs not being met by the churches in Prince George's County. The population of the church is growing older and many of the older members are not able to attend church due to various medical issues, some being confined to long–term care facilities. The churches are providing some ministry and services in nursing homes. The writer believes that the church must provide special attention to the spiritual and visitation needs of residents in nursing homes. Many residents do not get visits or telephone calls from their families and friends, especially if they are in the nursing home for a long period of time. There is a need for more visitation to the sick and shut–in. Residents in nursing homes are usually in the last stage of life. The church's mission is to minister to helpless, hurting, and lost. It is important for the church to reach out beyond the church walls for members and to touch the community and world with the love of God with their time, spiritual gifts, and talents.

In the past and even now, many of the aging sick stayed in their own homes or with family members until they died. Family members, neighbors, and friends would visit, bring food, and care for the sick and aging family members and neighbors before long–term care facilities became popular and financially feasible.

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[10] "2000 Census Data for Prince George's County, Maryland, Population by Age and Sex," available at http://www.mdp.state.md.us/msdc/pop_estimate_00to03/CensPopEst00_03htm accessed October 11, 2007.

[11] "2000 Census Data for Prince George's County, Maryland, 65 years and over, Institutionalized Population– Nursing Home in Prince George's County," available at http://www.mdp.state.md.us/msdc/census/cen2000/DOC/Web_Dictionary.pdf, accessed October 11, 2007.

The writer identifies the problems as the lack of trained volunteers, an awareness of the need to visit the elderly, and the lack of innovative programs. The writer is defining training as preparation and instruction in serving the residents in nursing homes. The outreach ministry of visitation and services to residents in nursing homes is not well promoted in the church. The hypothesis of this project is to develop a collaborative ministry model for ministry to nursing home residents, which includes a trained team of compassionate laity. The church must give special attention to the spiritual needs of residents in nursing homes. A ministry to residents in nursing homes is an opportunity to serve those who are unable to attend a regular church worship service. It is also an opportunity to impact the lives of the elderly by bringing sunshine and genuine love.

Collaboration

The interest for this project has grown out of a desire to fulfill the writer's own calling and passion to serve those who are underserved and to help other women who struggle with a call to ministry. Such a project will assist them in developing excellent skills in leadership as they serve the church and advance the kingdom of God while utilizing their talents and spiritual gifts. The context for this project grew out of a concern for the many social issues that plague the local community and the lack of sufficient outreach by local churches. The Women's Ministry Resource Center was established in Prince George's County in August 2002 to address some of the social problems affecting the local community. This project will be in collaboration with the Middle Atlantic Regional Gospel Ministry to address the needs of the elderly in nursing homes in Prince George's County.

CHAPTER TWO

STATE OF THE ART IN THIS MINISTRY PROJECT

Growing old is a long process that typically includes illness, physical losses, and time for reflection. One spiritual task of late life is to draw meaning and purpose out of why and how one has lived. For some, the experiences of life and aging produce negative attitudes such as feelings of neglect, loneliness, bitterness, self–centeredness, and despair. Others are able to find significance in the past, meaning in the present, and hope for the future. An elderly person whose faith has been tested and tried through life's experiences usually has a stronger, more mature faith as a result, and a testimony to share with others.[1]

One of the most difficult problems in later life is dealing with chronic illness, which can lead to total life change and loss of independence. Chronic physical troubles, ongoing physical losses, or impending death are some circumstances that might lead to an even closer contact with and dependence on God's grace.[2]

Many elderly individuals become chronically ill and disabled and are unable to care for themselves. Some have no family to care for them; other family members live in distant locations, making it difficult to care for them due to the extensive medical care required. As a result, for some individuals, the only option or recourse is a long–term care

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[1] Henry Holstege, *Complete Guide to Caring for Aging Loved Ones* (Wheaton, IL: Tyndale House Publishers, 2002), 299.

[2] Ibid., 301.

facility such as a nursing home. Nursing homes have received negative reviews because of abuses, neglect, and limited staff. The nursing home is a great place for ministry to residents who are not able to attend church due to institutionalized confinement.

Creating and developing an effective ministry model for residents in nursing homes can be challenging. It is important to create a relevant worship service and spiritual program that can minister to the well–being of the residents. The most prominent problem is developing a program that will serve the diverse population of aging elderly residents. At the same time consideration should be to the varying levels of disabilities that affect their ability to participate in a meaningful spiritual program. On–going obstacles prevalent in serving residents in nursing homes are also problems that affect the overall aging population. The problems of aging in America affect almost everyone.[3]

The purpose of this project is to develop an effective model for ministry that addresses the ministry needs and well–being of residents in nursing homes with the emphasis on religion and spirituality. The focus is on training a team of laypersons to provide relevant and innovative worship services and programs for residents in nursing homes. The growth of our aging population has increased the need for nursing home ministry.

Chapter Two will review the literature on the research that has been done in the area of aging residents in nursing homes, as well as other programs serving the elderly and disabled. A review of the relevant studies will help improve ministry to residents in nursing homes.

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[3] Alvin Rabushka and Bruce Jacobs, *Old Folks at Home* (New York: Free Press, 1980), 3.

Visiting the sick and ministering to their needs is a responsibility of the Church and all Christians. While the care of residents is the responsibility of the nursing or medical staff, which is usually secular, visiting the sick remains a distinct Christian duty as outlined in the twenty–fifth chapter of Matthew. All Christians are called to serve; some are called and ordained to serve those who serve, to "equip the saints for the work of ministry."[4]

Providing worship services in nursing homes and residential care facilities for the elderly is a challenge due to the physical, mental, emotional, and spiritual aspects of aging. This study explores and details the various issues that are faced in designing a Christian worship service in a nursing home environment. A 1997 study by Philip Baker and Paul Nussbaum states: "The majority of the current cohort of older adults value religion and are active in their religious practice."[5] A 1994 Gallup Poll conducted by the Princeton Religion Research Center (PRRC) reveals, "76% of persons over 65 years regard religion as highly important in their lives. Over half (52%) of all older persons reported attending religious services on a weekly basis."[6] It is generally understood that the "sacraments, traditions, and music in worship take on deeper meaning and significance as a person grows older and has lifelong memories associated with these practices."[7] As the physical hardships and economic realities of aging force people into community living situations, how will this need for spiritual connection and religious

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[4] Gregg D. Wood, "Paying Peter and Paul: Benefits of a Hospital–Based Lay Pastoral Visitation Program," *Journal of Pastoral Care* 40 (1986): 253–261.

[5] Geraldine G. Hamlen, "Challenges to Preparing and Conducting Christian Worship in Nursing Homes," *Journal of Pastoral Care and Counseling* 58 (2004): 325–334.

[6] Ibid., 325

[7] Ibid.

practice be met? In 1995, there were 14,264 licensed nursing facilities and 44,564 licensed residential care facilities in the United States, with a total 2,488,936 beds. This is a huge congregation in need of spiritual services.[8]

The three major challenges to conducting a worship service in nursing homes are diverse resident population with various types of disability or impairment, space and scheduling, and planning a worship service that minister to diverse group of individuals with various religious backgrounds. These challenges can be managed with the help of the Lord. It has been documented that meaningful Christian worship can be brought to congregations of aging nursing home residents through careful planning. It is important to act as a servant of the Lord. Creating space and time that allows people to pay attention to the presence of God is a valuable gift and service to God's people.[9]

According to Wood, it should be the policy of all Christian churches to encourage the development and exercise of a lay ministry. It is Wood's view that training of a lay pastoral ministry should take place where the service will be provided or in a new environment that the trainee enters for the purpose of training, in which the training opportunities are maximized and properly supported. Wood contends that a well–structured lay program will benefit those individuals who need encouragement and support. He indicates that not only will patients and their families benefit, but also the institution's staff as well, for there are more trained individuals available to minister. The church benefits because it has lay pastoral visitors who are trained. The individual lay minister is better equipped because he or she is able to exercise and utilize ministry and

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[8] Ibid., 325.

[9] Ibid.

spiritual gifts.[10] Although this training of lay ministers was geared to lay chaplains, it can be adapted to use in the nursing home situation.

In a study on developing a caring atmosphere to the elderly by lay volunteers, Compton's hope was to affirm the laity of the church who were already visiting the aged, and help them develop their skills in ministering to the aged and elderly. It was also his desire to motivate other congregants to visit the aged. This project seeks to encourage the church to function biblically as it presents the fact that ministry is not the responsibility only for the pastor but the entire congregation. As a result of visiting the aged, the pain of those who are grieving over drastic changes was eased.[11]

Elderly people who must reside in nursing home facilities often face unique problems. These frustrations often center on the trauma of leaving comfortable home surroundings to reside in an alien environment, which brings unfamiliar faces, loneliness, and unwelcomed new adjustments.[12]

The mission of ministering to institutionalized older persons presents a task to provide a well–planned and committed pastoral care effort. The Lutheran Council U.S.A. undertook several steps. It established a Task Force on Ministry to the Aging in Institutions as a method of targeting the pastoral need of nursing home residents. A survey was designed with the aim to determine the needs of the elderly regarding pastoral visitation and interaction with clergy, which included family ministers and facility chaplains. One of the questions asked on the survey was how important church (or

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[10] Wood, "Paying Peter and Paul."

[11] Compton A.L Williams, "Developing a Spirit of Caring through Lay Visitation to the Aged" (Ph.D. Diss., Drew University, 1994), in ProQuest Digital Dissertation [database on–line], available from http://www.proquest.com/publication number AAT 9527274, accessed February 7, 2008.

[12] Jerry Uhlman, "Pastoral Care for the Institutionalized Elderly: Determining and Responding to their Need," *Journal of Pastoral Care* 39 (1985): 22–30.

religion beliefs) had been to them throughout their lives, and how much they relied on their minister or others in church. The majority of nursing home residents indicated that church was very important, however those in a facility more removed from church felt less strongly. Over sixty–five percent of the residents attended a religious service regularly. Prayer and focus on God's love received highest preference. A majority of the residents relied on a minister or chaplain for their spiritual help. Family members were also an important source of encouragement. For this study, the church had assumed significant importance before entering nursing homes.[13]

Survey data suggests that where clergy visitation was frequent, there was a higher reliance on clergy for spiritual help; whereas less frequent visitation, residents expressed less reliance on clergy for spiritual help. In personal interviews, it was quite evident that the elderly truly enjoyed talking with family ministers.[14]

The residents of nursing homes value the importance of prayer. It was reinforced by its high rank among the foci of religious services. A service with prayer, scripture, and sacrament, which focuses on God's love, seems to be most appreciated and enjoyed.

Personal contact and key devotional elements provided a positive and uplifting manner, can be combined to give the elderly ministry to their particular needs. The pastor or nursing home team who provides visitation as an integral part of ministry can give the elderly in nursing home both spiritual enrichment and a treasured link to their congregation.[15]

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[13] Ibid.

[14] Ibid.

[15] Ibid.

Friedman indicated in a 1995 study that religion positively affects the well–being of nursing facility resident by providing solace, a sense of personal meaning, and connectedness to the world. Seeber's research in 1995 also shows that religion provides a sense of identity and meaning during times of uncertainty and loss, significant issues for nursing facility residents. Koenig in 1994 writes that frail elders must have an opportunity to nurture their relationships with God through prayer, scripture, and worship. He further states spiritual needs are intimately related to the physical and psychological health of the person and cannot be ignored. It is important for congregational leaders, lay ministers, and health professionals to acknowledge these needs in their work with older adults. MacKinlay in 2001 developed a framework for inventions by health professionals, clergy, and lay ministers that can be used to meet the spiritual needs of older adults in nursing facilities.[16]

Koenig in 2001 notes that chaplains, congregational leaders, and lay ministers are trained to provide spiritual support; however at times find themselves meeting many psychological and social needs of patients. Aging, illness, and loss of control often mean confronting dependence and human limitations. Ministers assist persons in coping with those changes and losses. Cassern as cited in Koenig's 2001 research discusses eight essential features of "whole person care" applicable to meeting the physical and psychological needs of older adults in nursing facilities: competence, concern, comfort, communication, visits from children, family cohesion, cheerfulness, consistency, and perseverance.[17]

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[16] Patricia Gleason–Wynn, "Enhancing the Quality of Life for Older Person: Ministry in Nursing Facilities," *Journal of Family Ministry* 17 (2003): 39–41.

[17] Ibid., 39.

According to Stein (2001) in four White House Conferences on Aging, religious communities were asked to reach out to their older members, monitor nursing facilities, and offer services for older adults to address spiritual isolation. When persons relocate to a nursing facility, they often find themselves isolated from their community, including their community of faith. Access to religious instruction, rituals, and fellowship are likely limited by the move to the care facility. This challenges religious professionals and lay ministers in faith communities to take religious tradition, rituals, and services to the congregants living in nursing facilities.[18]

Friedman articulates several reasons that ministering to the spiritual needs and assisting in the continuation of religious or spiritual practice is important for residents in nursing facilities:

1. Religious rituals create a sense of continuity, connecting the resident to the past and providing hope for the future.
2. Religious involvement provides a sense of meaning, a sense of significance, and a promise of celebration.
3. Religious life allows for sharing a community, finding a common bond with others, and a connection to the faith community outside the walls of the facility.
4. Pastoral care affirms for the residents that God continues to care for them.[19]

Ministry in nursing facilities can be very difficult and may be resisted by congregants and by congregational leadership. However, ministering in nursing facilities is fulfilling for the residents in the facility and can be rewarding for the religious and lay ministers of religious communities.[20]

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[18]Ibid., 40.

[19] Ibid.

[20] Ibid.

One area of concern is that congregational leaders and lay ministers may lack training and understanding of the aging process, what life is like in a nursing facility, and how nursing facilities operate. Religious leaders and lay ministers may not know what spiritual care services are needed by the residents. Residents need more than a formal worship service once a week to enhance their spiritual well–being.[21]

In a recent, study at Duke Hospital of 87 elderly patients who had multiple chronic medical illnesses and were in great distress over their condition, those who scored highest on intrinsic religiosity (on personal faith in God) recovered significantly faster from emotional distress than did persons with lower intrinsic religiosity.[22]

In fact, having strong religious faith had an even greater effect on emotional healing than did changing physical healing and functioning. Elderly patients were asked how they have used their religious faith to help them better cope. Their common response of coping was "by placing trust and faith in God." Many elderly said that they simply turned their situation over to God and let God take care of them. They were then able to stop worrying and stop trying to work the situation out by themselves. Even though they did not have any control over the situation, they believed that God did, and God would respond to their prayers and take care of things. This brought consolation and relief from worry or depression.[23]

Reading the Bible or other inspirational literature was another way that older patients frequently coped. Many could not describe why this made them feel better, but it

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[21] Ibid., 41.

[22] Harold G. Koenig and Andrew J. Weaver, *Pastoral Care of Older Adults* (Minneapolis, MN: Fortress Press, 1998), 71.

[23] Ibid.

did. Some said that singing religious hymns lifted their spirits. Others said that visits and prayers from clergy and church friends were helpful in enabling them to cope with health problems. The study suggests that patients believed that knowing that everyone had prayed for them during the church service often brought comfort.[24]

These responses give clues about how clergy and religious caregivers can help persons use their faith to help them to cope with chronic illness. Helping the elderly to realize that God is present, has their interests at heart, and has a purpose for their lives will give them a sense that they are not alone in their struggle.[25]

It has been asked by a number of individuals including clergy and lay ministers on how they might be more effective in developing ministries with older persons. Dr. Oliver in his research states that a ministry is never to, or for older persons, but a ministry must be thought in terms of a ministry *with* older persons. Oliver states that no successful aging program started with a committee to organize it. Instead, one or two persons dedicated to getting something started initiated it.[26]

Dr. Oliver suggests that every religious community should have a lay visitation program which guarantees that every nursing home resident, hospital patient and homebound member gets a visit at least one each week. He states that the minister, priest, or rabbi should not be the main force, which organizes and sustains a ministry involving older persons. It should be a lay ministry because they are in better position to

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[24] Ibid., 72.

[25] Ibid., 73.

[26] David B. Oliver, "Reflections on the Role of the Church, Synagogue, or Parish in Developing Effective Ministries with Older Persons," *Journal of Religious Gerontology* Vol 12, no. 2 (2001): 37–39.

insure greater continuity and history. Dr. Oliver purports that a variety of programs should be developed because each older person is unique with different interests.[27]

One of the significant groups of people that every pastor needs to be able to engage through ministry is the elderly. While older persons constitute eleven percent of our society, they often make up a much larger portion of our congregations. In an effort to address the question of training needs to be considered when educating for ministry with elderly, a survey of parish clergy was carried out. The results emphasize the importance of training for clergy and lay persons who work with the aged. It was found that the elderly turn to the church and the clergy for emotional or non–medical assistance. It is important that church and clergy have the skills necessary to work with the aged. The findings suggest empathy and small group leadership are the two skills for which the participants felt best prepared. Several persons felt that empathy is not only an important skill essential to ministry, but that it was also a gift of God.[28]

Dr. Klapp developed a model of ministry specially designed to include persons with Alzheimer's disease in worship at nursing facilities. Validation techniques, which are comparable with Biblical teaching and principles, were found to be viable means of engaging residents in meaningful worship.[29] She states that a major barrier for ministry to institutionalized persons with Alzheimer's disease is difficulty in communication.[30] Dr. Klapp believes that worship is the most important thing Christians do and therefore the

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[27] Ibid., 41–42.

[28] James W. Ellor and Robert B Coates, "Ministry with the Elderly: Training Needs of Clergy," *Journal of Religious Gerontology* Vol 12, no. 2 (2001): 29–33.

[29] Derrel Watkins, *Practical Theology for Aging* (Binghamton, NY: The Haworth Pastoral Press, 2003), 153.

[30] Ibid., 162.

most important aspect of faith to make accessible to the "least of these." It is the primary "mode of remembering and expressing Christian faith."[31] Essential to the expression of worship are singing, reading, and the proclamation of the Word in the midst of the gathered community. A worship experience for the resident with Alzheimer's disease may be the only opportunity for the long forgotten memories of childhood songs, fragments of Scripture and religious acts to be stimulated and remembered. Worship that includes corporate prayer gives opportunity for the person to spiritually link with others in fellowship with God through the Holy Spirit.[32]

Studies show that belief in God is stronger among the elderly than in other age groups. The National Opinion Research Center in 1998 found that the largest percentage (71%) of those that were "absolutely certain" there was a God were age 65 and over are the most religious with less doubts than younger adults are.[33]

A 1982 Gallup survey reported that 82 percent of the elderly felt that religious faith was the most important influence in their lives, and 23 stated they had a very high spiritual commitment. Because older people attach more importance to religion than younger adult do, and belief in God is stronger among the elderly than other age groups, many researcher have concluded that religious feelings increase with advancing age. Studies of this relationship have typically been based on cross–sectional data that compare older and younger people at the same point in time.[34]

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[31] Ibid., 153

[32] Ibid., 158.

[33] Diana K. Harris, *The Sociology of Aging* (Lanham, MD: Roman & Littlefield Publishers, Inc., 2007), 205.

[34] Ibid., 205–206.

Many investigators have shown positive relationships between religious activities and well–being among older persons. A study by Moberg and Taves in 1965 investigated the relationship between church participation and adjustment in old age. They found that church members had higher personal adjustment scores than nonmembers and that church leaders had higher scores than other church members. The researchers concluded that the evidence overwhelmingly supports the hypothesis that church participation is related to a good personal adjustment in later years. Blazer and Palmore in 1976 found that for the elderly, happiness, a sense of usefulness, and personal adjustment are significantly related to religious activities and attitudes.[35]

Religion functions at two levels: the psychological (individual) level and the social (or group) level. For individuals who in faith accept the basic teaching of a religion, religion may perform certain psychological function during the later years, such as helping to face impending death, to find and maintain a sense of meaningfulness in life, and to buffer the impact of stress. At the social level, the church helps to reduce isolation of the elderly by affording them the opportunity for social relationship and friendship. The relationship between religious involvement and personal adjustment is still unclear. Moberg suggests that "either those who are well–adjusted engage in many religious activities contributes to a good adjustment in old age."[36]

The Department of Veterans Affairs has several long–term care units with their hospital system, and one of these is located in Lyons, New Jersey. One of the chaplains undertook the task to train a group of patients from the facility to reach out and give

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[35] Ibid., 208.

[36] Ibid., 209.

spiritual care to their fellow residents. The facility had a wide range of patients, not all the usual kind that one thinks of in nursing homes. The researcher revised a training program that had been used in a hospital setting and in the parish with volunteers and church members. The training program was adjusted to suit hospital residents themselves. The program consisted of six sessions, each building on the previous sessions and using feedback from the Team who was encouraged from the beginning to visit and report their experiences to the whole group. There was a stress on listening to one another and to putting one's own needs on temporary hold. The team was excited by the prospect of learning how to reach beyond their own needs and concerns. Seven members finished the program and received a certificate.[37]

In this study on the role of the chaplain in today's nursing home, Dr. Kimble discusses the evolving role of the chaplain in the healthcare system and society–at–large. Traditionally, the long–term care chaplain was a clergyperson who ministered in a congregational setting, prior either to his /her long–term care ministry or simultaneously with it, often on a part–time or rotational basis. These chaplains had good intuitive skills, but no training in the field of gerontology. This has become important, because gerontology is a fast–growing field of knowledge that has yielded many insights regarding care of the aging. Growing with it is recognition of the need for a holistic, interdisciplinary approach to today's residents' care.[38]

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[37] Leslie Ann Depenbrock, "Formation of a Pastoral Care Team in a Long–Term Care Facility and Training Residents as Pastoral Care Visitors" (D. Min. Diss., Drew University, 1993), in ProQuest Digital Dissertations [database on–line], available from http://www.proquest.com/ (publication number AAT 9410453), accessed February 7, 2008.

[38] Melvin Kimble, "Who are Today's Chaplains?" *Nursing Home: Long Term Care Management* Vol.46, Issue 10 (Nov/Dec 97): 37–38.

Many practical issues arise in defining the chaplain's role in the long–term care setting. One example of this issue is training. There is a concern that many chaplains might not have sufficient access to the new knowledge available from gerontology. Several organizations in long–term care and in religion are collaborating on training courses for chaplains. The chaplain has a crucial role in today's long–term care facility and it is important for the chaplain to grow in understanding of the needs of aging residents.[39]

In some churches, deacons serve in ministries to the elderly and residents in nursing homes. In the book, *Equipping Deacons in Caring Skill*, Carter states the deacon's ministry is a shared ministry. Deacons are called to partnership in ministry under the leadership of the pastor. Although all believers are responsible to care for and minister to one another, the deacon can lead the way in ministry and model care for the entire congregation. Deacons need to be equipped for such a caring ministry. This means deacons need to develop basic caring skills and learn to apply them in specific ministry situations. These skills do not substitute for the spiritual power essential for God–given ministry. Power for ministry comes directly from God's presence. A key to Jesus' caring ministry is his sensitivity to the needs of others. Sensitivity comes as a gift from God through wise perceptivity. Experience helps a deacon become aware of signals of loneliness, doubt, guilt, or depression.[40] The purpose of good training for deacons is to prepare them for situations that may occur in a ministry situation.[41]

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[39] Ibid., 38.

[40] Homer D. Carter, *Equipping Deacons in Caring Skills* (Nashville, TN: Convention Press, 1980), 10.

[41] Ibid., 11.

Stephen's Ministry is a national training program designed to equip lay people to provide one–on–one Christian support to individuals dealing with emotional, physical, or spiritual problems. A Stephen's minister can help sort out feeling and thoughts as they reflect the love of Jesus Christ. Stephen's ministers help the hospitalized, the homebound, the terminally ill and their families, those who are depressed or grieving a death or loss, those who are in spiritual crisis and others. Thousands of congregations are enrolled in the St. Louis –based Stephen's Ministry program. This ministry program represents ninety denominations.[42]

In the book, *Enabling the Elderly*, Tobin has developed a model for increasing interaction by developing allies with social service agencies. It is Tobin's belief that churches and synagogues can work singularly or collectively with community agencies to improve services to the elderly. These processes take time and commitments, but the potential benefit to other people is worth the effort.[43]

Lack of knowledge about the types of programs and services that each group has to offer is one type of problem. The use of different language to express themselves as well as different strategies for taking action is another problem. In order to encourage collaboration, each group needs to understand the strategies and language of the other.[44]

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[42] Henry Holstege and Robert Riekse, *Complete Guide to Caring for Aging Loved One* (Colorado Springs, CO: Focus on the Family, 2002), 314.

[43] Sheldon S. Tobin, James W. Ellor, and Susan M. Anderson–Ray, *Enabling the Elderly: Religious Institutions Within the Community Service System* (New York: State University of New York Press, 1986), 174.

[44] Ibid., 172.

Other problems that affect the churches and other agencies together involve the church's perception as primarily a religious institution. Other problem consideration includes the availability of resources to develop new programs.[45]

The Legion of Mary is the largest apostolic organization of lay people in the Catholic Church, with well over 3 million active members in almost every country of the world. It has been active in the United States since 1931, has been approved by the last six Popes, and was endorsed by the Second Vatican Council. The main purpose of the Legion of Mary is to give glory to God through the sanctification of its members.[46]

Members become instruments of the Holy Spirit through a balanced program of prayer and service. Works include door–to–door evangelization, parishioner visitation, prison ministry, visitation of the sick or aged, crowd contact, religious education, visiting the newly baptized, Pilgrim Virgin Statue rotations, and meeting the other spiritual needs of the parish community. Legionaries are under the guidance of a spiritual director named by the pastor. The Legion is, in essence, an extension of the heart and hands of the pastor Members meet once a week for prayer, planning, and discussion in a family setting. Then they do two hours of definite work each week in pairs and under the guidance of their spiritual director.[47] Organizations like the Roman Catholic Legion of Mary are able to keep in touch with many.[48]

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[45] Ibid., 173.

[46] "Legion of Mary," available at http://www.legion of Mary.org/lom.html, accessed January 18, 2008.

[47] Ibid.

[48] Ian S. Knox, *Old People and the Church* (New York: T. & T. Publishers, 2002), 242.

Virginia Stem Owens wrote an article in "Christianity Today" about caring for older people and her experiences with her mother at Fair Acres Nursing Home. She states that caring for elderly will be one of the major challenges to the nation in the next decade. She found that local churches held regular services or Bible study at Fair Acres, but few churches in this country actually own or operate nursing homes. The few churches that own nursing homes cater to retired clergy. In her research, she found that two–thirds of all nursing home residents have no regular visitors. The residents of Fair Acres value companionship above all, someone to listen to their stories and tell them what is happening in the outside world.[49]

Pamela Hart has used the Psalms as resource in her ministry to nursing home residents. In her study, she states that while much of our information about aging comes from textbooks and life experiences, there is much that can be learned from reading the Psalms.[50] The book of Psalms speaks with and for the afflicted and for this reason is particularly helpful in nursing homes and to chaplains and ministers and lay visitors who call on them.[51] Psalms show that people do not have to hide our feeling about life, or do not have to deny the hurt they feel. Psalms show that people can take everything that disturbs them to God and trust their problems to the Holy One.[52]

Hart states that preaching from the Psalms offers a chance to speak to the unexpected and unhappy changes that come to everyone in life. She found one collection

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[49] Virginia Stem Owens, "The Visit," *Christianity Today* Vol. 48, Issue 9 (September 2004): 60.

[50] Pamela S. Hart, "The Psalms as a Resource for Nursing Home Ministry," *Journal of Religious Gerontology* Vol. 12, no. 2 (2001): 61.

[51] Ibid., 62.

[52] Ibid., 63.

of sermons called Sermons from the Psalms by Clovis G. Chappell to offer a resource for developing sermons for nursing home patients.[53]

Hart emphases that *The Message of the Psalms* by Brueggemann suggest that the Psalms were written for liturgical purposes. She states that the study of Psalms as a resource in nursing home ministry continues to influence how she ministers to older persons, and gives her a deeper understanding of life and help her realize that human cries of anguish come out of an intolerable life situation.[54]

Music is a source of worship in the Christian church. In a study, the researcher believed that there is a deep spiritual consciousness that can be reached through music with late–stage Alzheimer's conditions even when there is no functioning cognitive awareness. Several residents in the Woodcliff Lake Manor Care Center participated in this study. It was found that music helped residents rediscover their youthful joy. Music created deeper relationship for the residents, and improved their self–esteem.[55]

Hairdressers in the Marketplace (HIM) is a ministry at Willow Creek Community Church in suburban Chicago operated by volunteers. It includes a group of dedicated professionals who venture into the community to serve residents in nursing homes. In addition they serve others including the poor, homeless shelters, and facilities for the mentally handicapped. This ministry goes out once a month to provide a day of beauty sessions where women in need receive free pampering, from haircuts to manicures, but

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[53]Ibid., 65.

[54]Ibid., 67.

[55]Grant James Scott "Spiritual Moments with Precious People: A look at Music and Transformation in a Long–Term Care Center" (Ph.D. Diss., The Fielding Institute, 1999), in ProQuest Digital Dissertation [database on–line], available from http://www.proquest.com/ (publication number AAT 9950742), accessed February 9, 2008.

also hear about God's love for them. These hairstylists are bringing their talents and truth to people in need of a touch of love.[56]

Ministering to the elderly will continue to be a challenge in the coming years due to the large number of baby boomers who are reaching the age of retirement and many needing care. Church must begin to plan to make accommodations and plans to serve the large number of individuals reaching old age.

The church must begin to plan for this increase in ministry to long–term care facilities by preparing church outreach programs to reach out the walls of the local church. Three common themes in the finding suggest that there is a need for training for all individuals who minister in nursing homes, a need for visitation from the church and family, and need to do develop relevant worship services.

The research indicates that all individuals regardless of their position need to have training in ministering to the residents in nursing homes as well as knowledge of the aging process. In order to be effective in serving the chronically ill and disabled elderly, individuals who visit must be trained in listening, responding appropriately, and having an understanding of emotional and mental changes that are affected by the aging process.

The church must recognize the importance of visiting the elderly who are unable to attend church due to chronic illness, homebound due to lack of mobility, or being a resident in a long–term care facility such as a nursing home. A church visitation ministry is very important to the elderly because it connects them with the outside world and with the church.

Another important aspect of improving ministry to the residents in nursing homes is developing and implementing a relevant and innovative program. Worship services and

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[56] Keri Wyatt Kent, "Pampering with a Purpose, "*Today's Christian Woman* (Nov/Dec 2006), 54.

one–on–one visits should be well planned with the thought of a meaningful experience for the residents.

CHAPTER THREE

THEORETICAL FOUNDATION

As the church prepares to address new challenges in the twenty–first century, it is incumbent upon the current and future leaders to engage in a new, more comprehensive view of its future mission and ministries. African American church leaders must guide the church in developing a plan of service that maintains its past history of ministry while acknowledging the existence of an aging population that presents new and radically different challenges and needs.[1]

The purpose of this project is to develop a collaborative ministry model for the chronically ill and disabled residents in nursing homes. This model will represent a collaborative effort with churches, ministries, nursing home staff, and social agencies. The church must give special attention to the spiritual issues and needs of the chronically ill and disabled in nursing homes and other long–term care facilities. When medical crisis occurs the sick and disabled need the assurance of a caring faith community. The church's mission is to serve the hurting, the sick, the needy, and the lost. A ministry to residents in nursing homes is an opportunity to serve the spiritual needs of those who are unable to attend a regular church worship service.

The context for this project is the Ministry Resource Center, a Christian community outreach ministry located in Mitchellville, Maryland. The center is composed

[1] Bobby Joe Saucer and Jean Alicia Elster, *Our Help in Ages Past: The Black Church's Ministry among the Elderly* (Valley Forge, PA: Judson Press, 2005), 1.

of a network of women working to serve the spiritual needs of those in long–term care facilities.

This chapter explores the historical, Biblical, and theological foundation of the need for an effective ministry in nursing homes. The historical section explores the problem facing our country with a large aging population and the transition of the care of the chronically ill and disabled from the family home to long term care facilities outside the home to nursing homes.

The Biblical study is an exegesis of Psalms 71:9 in the Old Testament and John 5:2–9 in the New Testament. Both scriptures emphasize that God is concerned and cares about the sick and disabled.

The theological section explores the care and compassion of the ministry of Jesus and the call for the church to reach out to the sick, the disabled, and those in need.

History of Long Term Care

This section is a comprehensive overview of how our long term care system has evolved by examining the events and decisions that changed the way that we have provided and paid for the care of our elderly over the years.

The United States in the 1700s was predominately comprised of young people for a variety of reasons. Life expectancies were much shorter than they are today, primarily because so many people died in infancy or childhood. That meant that a relatively small percentage of the population lived to old age.[2]

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[2] Karen Stevenson, "History of Long–Term Care," (2006), available at http://www.elderweb.com, accessed February 12, 2007.

Other than the Native Americans, the country was populated almost entirely by immigrants, many of whom came from England or other parts of Europe. Getting here required an extremely hazardous ocean voyage, and life on the new continent was equally difficult. The immigrants who came here voluntarily were either fleeing from persecution or were poor and hoping for a better life in the new world, the only reasons they would take such a risk. The colonists came to the new world seeking religious and political freedom and economic opportunity. They brought hope, faith, determination, and dreams. Few people who were old or ill would have attempted such a trip, and many of those who did probably died in the process. The slave population was also young. Slave–traders were not going to waste their time bringing over those who were old or ill, and relatively few slaves survived long enough in the harsh conditions that most of them would have endured to live to old age.[3]

In the early years of this country, few people lived to old age, but for those that did, "old–age security" meant having children or property. Having family living nearby was not often an issue. In those days before railroads and automobiles, families were large and few children ventured far from home.[4]

The immigrants brought their system of law and the communal structure that evolved over the centuries in their native lands. They believed and required that all able bodied individuals should work. They agreed that the lamed, sick, blind, orphaned, and elderly could be cared for in communal facilities, which became known as almshouses.

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[3] Ibid.

[4] Ibid.

Almshouses were built in Boston in 1622, in Philadelphia in 1713, and in New York in 1736.[5]

Before 1800, less than five percent of the U.S. population lived in cities. Everyone else resided in rural areas where extended families could live together easily and cheaply. Generally, people worked for themselves. Having a large family was the key to survival. As later described in a Social Security pamphlet,

> A young man then could hardly afford not to marry. He needed a wife as a business partner,and children as helpers. In early New England not only spinsters but bachelors were under a cloud. Bachelors, in fact, were regarded with suspicion. Usually they had to live where the court told them to. Single people had to attach themselves to a family to get a chance to work for their living. Both the children and the old people earned their place at the family table.[6]

Children were expected to split their earnings with, or otherwise provide for, their parents. If a parent needed care, the children were expected to provide it. Elderly people in need of care who were childless but wealthy could hire whatever help they needed. Dependent elderly people who could not be cared for by their own families could be "boarded out" with surrogate families, and the adult children paid for the cost of that care. Those elderly who were poor and childless, or whose children refused or were unable to care for them, ended up dependent on charity or public welfare.[7]

Early in the history of our country, there were no government agencies or programs. Relief was a local responsibility and was dispensed either by the local community, church, or organization formed to meet the social, cultural, and religious

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[5] Seth B Goldsmith, ed., *Long–Term Care Administration Handbook* (Gaithersburg, MD: Aspens Publishers, 1993), 12.

[6] Stevenson, "History of Long–Term Care."

[7] Ibid.

needs of the immigrant group. There were associations, clubs and societies to ensure that the poor would be clothed, housed, and fed, the sick visited, the prisoners ransomed, and the deceased buried. These early organizations, some known as the "Ladies Sheltering Aid Society," and similar names were established so that those without families and in need of help would be cared for. These voluntary philanthropic, fraternal, ethnic church–related homes were the primary types of facilities providing services throughout the 19th century and up to the early 1920s.[8]

Very little has been written about how slave owners behaved toward their aging slaves. Treatment has been described as oppressive, barbaric, or at best indifferent. Although in some instances, old slaves were treated with kindness. Some old slaves were treated like "worn–out farm animals," and the practice of abandonment was widespread.[9]

Slaves, of course, had neither families nor property. Their families were often split up, so it would have been impossible for children to look after their own parents. The quality of their life in old age was completely dependent on the master they worked for.[10]

African Americans facing solidifying racial barriers could not obtain medical care or other services. In response they turned to vigorous activism on behalf of their elders, particularly through the churches and women organizations, they founded numerous homes for the aged and strengthened their long history of mutual help.[11]

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[8] Goldsmith, *Long–Term Care Administration Handbook.*

[9] Robert H. Binstock, ed., *The Future of Long–Term Care: Social and Policy* (Baltimore, MD: Johns Hopkins University Press, 1996), 204–205.

[10] Stevenson, "History of Long–Term Care."

[11] Binstock, *The Future of Long–Term Care,* 25.

The first benevolent society for Blacks was founded by free African Americans in 1789. The Free African Society, born in the African Methodist Episcopal Church, dedicated itself to mutual support in sickness and in widowhood. The Prince Hall Fratenal Order founded in1787 offered social services, collected and distributed sick dues, and provided pension to the elderly and compansionship for the sick and disabled. By 1899 Philadelphia had approximately 106 benevolent societies involving one–half of the adult Black population.[12]

As the attitudes toward the aging and old became harsher in this period, the moral standard of "worthy" and "unworthy," heretofore reserved for the younger, able–bodied in matters, were also applied to the old. The Quakers and African Americans opened the doors to a home for "worthy and exemplary colonial people" in recognition that racism, not bad character, had made them poor.[13]

Poorhouses became homes for the indigent elderly. The Poor Laws established the government's responsibility to provide for those who could not care for themselves, but left the details about how to do it up to the local town or county officials. They built poorhouses, almshouses, poor farms, county infirmaries, asylums, or county homes to house people who were too expensive to support with outside relief, and required welfare recipients to go to these facilities if they wanted assistance. Concerns about the high cost of operating the poorhouses lead to other indignities.[14]

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[12] Ibid.

[13] Ibid., 23.

[14] Stevenson, "History of Long–Term Care."

As time passed, the poorhouses became catch–alls for anyone who could not survive in the outside world, and they became home to poor dependent elderly people, where they lived in the same rooms with criminals, alcoholics, orphans, unwed mothers, and the mentally ill.[15]

One alternative to sending people to the poorhouses was to make cash payments to specific groups of disabled or indigent people to help them support themselves in their own homes. One of the first acts of the new government in 1776 was to authorize pensions for disabled Revolutionary War veterans. The initial military pension law offered half–pay for the rest of their lives to soldiers who were so disabled after the war that they were unable to work for a living. The federal government and the states disagreed about who should pay for and administer the program.[16]

In the 1800s, families began to disperse and children moved away. The westward migration of the country contributed to the dispersion of families. Although a few families took their elderly relatives along on the difficult journey West, a number of the western settlers left their parents and other relatives behind in the East.

Many elderly people lived with their children. Family living arrangements have always had impact on the need for long term care. Women were less likely than men to have accumulated assets of their own that they could use to take care of themselves in retirement; and unmarried people of both sexes were more vulnerable in old age because

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[15] Ibid.

[16] Ibid.

they had no partner who could provide them with physical and financial assistance. The most vulnerable group of all was unmarried elderly women.[17]

Older unmarried women had to rely on children of other family members for help and often ended up living with them. Ten perccent of married women and nearly sixty percent of unmarried women age sixty-five or older were living with children or other family members as dependents in 1890.[18]

The existence of family support was a crucial factor in mediating the effect of declining physical and mental functioning. When these resources declined the risk of institutionalization increases greatly.[19]

The poorhouse population exploded in the early 1800s and conditions in the poorhouses ranged from barely tolerable to horrific. The insane patients, criminals, and alcoholics frightened, and sometimes injured, and the frail elderly lived in the same rooms.[20]

In spite of the problems of the poorhouse system, most people seemed convinced that building large institutions was the best way to deal with those who needed help of one kind or another. In the newly industrialized society these institutions built to efficiently care for the poor, the sick, and the elderly bore a resemblance to factories. They were large, warehouse–like buildings that housed dozens, or even hundreds, of

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[17] Stevenson, "History of Long–Term Care."

[18] Ibid.

[19] Colleen and Leslie A. Grant Johnson, *The Nursing Home in American Society* (Baltimore, MD: Johns Hopkins University Press, 1985), 19.

[20] Stevenson "History of Long–Term Care."

people. Inmates slept in huge dormitories, with their beds neatly organized into rows, and ate at huge tables in a dining hall where meals could efficiently be served.[21]

The poor and the insane customarily resided in the home with family. In the Colonial era, the orphan was apprenticed to a household. The criminal, after being fined and perhaps whipped, was then returned to his residence. The 18th century community had recourse to institutionalization only when some extenuating circumstance—such as debilitating illness or violent insanity—made no alternative arrangement feasible. These ad–hoc institutions that came into being during the colonial era resembled the household both in routine and construction.[22]

In the decades after 1820, America turned with unprecedented enthusiasm and energy to the construction of custodial institutions for the poor, the insane, the orphan, and the criminal. Institutionalization now became the first rather than the last resort. The institution, and not the household became the preferred setting. Americans during these years also seem to have shared a confidence in the ability to design an environment in which these faults could be eliminated and the causes of dependency eradicated. The institutions built after 1820 were more influenced by and more nearly resembled the factory; whereas those built before 1820 more nearly resembled the household.[23]

In response to the problems of the poorhouses, numerous nonprofit organizations began building old age homes to give "respectable" poor people a way to avoid the degradation of the poorhouse. Benevolent societies and fraternal organizations

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[21] Ibid.

[22] Ibid.

[23] Stevenson, "History of Long–Term Care."

affiliated with nearly every ethnic, religious, trade, profession, and social group imaginable were established during the 19th century. Hundreds of benevolent societies emerged, including the Irish Benevolent Society, the German Benevolent Society, the Hebrew Benevolent Society, the Odd Fellows, the Masons, and the Knights of Columbus. These were called "voluntary" organizations because each eligible person could choose whether or not to join.[24]

In the beginning of the nineteenth century, women and church groups began to establish special homes for the elderly. Often concerned that worthy individuals of their own ethnic or religious background might end their days alongside the most despised in society, they established—as the founder of Boston's Home for Aged Women (1850), explained—a haven for those who were "bone of our bone, and flesh of our flesh." Advocates for these asylums contrasted their benevolent care with the horrors of those who were relegated to the almshouse. "We were grateful that through the indulgence of Divine Providence, our efforts have in, in some degree been successful, and have preserved many who once lived respectfully from becoming residents of the Alms House," wrote the organizers of Philadelphia's Indigent Widows' and Single Women's Society, one of the nation's earliest old age homes, in 1823.[25]

Although they had other purposes for their existence, the benevolent societies created one of the earliest organized old–age assistance programs. Members paid monthly dues to the Society while they were young and healthy, then received help when they were elderly, infirm, or in need. The Societies provided cash and food to support people

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[24] Ibid.

[25] Carole Haber, *Old Age and the Search for Security: An American Society* (Bloomington, IN: Indiana University Press, 1994), 130.

in their own homes. Since that was not enough for older members who could not live alone any longer, the benevolent societies began to build "homes for the aged" where their elderly members could live. The significant expenses of erecting and maintaining these buildings were paid for by the members of the benevolent societies.[26]

Some of the earliest voluntary homes were designed to house both orphans and the elderly, but eventually state–run orphanages were built and the orphans were moved into them. As that happened, the benevolent societies closed down their facilities for children and concentrated their attention on the elderly.[27]

We can trace three paths of the origin of today's nursing home. One is the local almshouse or county poor farm. The second is the private home for the aged, first established by charitable organizations just before the turn of the century, to provide shelter and maintenance for the well elderly who were of limited financial means or without benefit of family. The third is the private proprietary boarding home which emerged about the same time as the house for the aged but which catered to those able to pay for the supervision and personal care that such homes offered. [28]

In studying the evolution of long–term care, it is important to understand the way that hospitals were evolving, since there was some overlap between "old age homes" and "hospitals." Hospitals have some roots in the poorhouse system, just as nursing homes. Many of the poor were old and sick as well as many of the old and sick were poor. Some of the first hospitals in the country were built on poor farms to house the sickest of

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[26] Stevenson, "History of Long–Term Care."

[27] Ibid.

[28] Burton, *The Growth of Nursing Home Care,* 100.

the poor population. Where there was no poorhouse hospital, private hospitals received money from the county poor fund to care for the sickest paupers, which often made up a significant percentage of their patients. A few poorhouse hospitals, like Cook County Hospital in Chicago, still exist today as public hospitals.[29]

Nineteenth century hospitals were not places where you expected to be cured, they were places to go when all other options had been exhausted. In the early part of the century medical science was very crude and often consisted of "cures" like bloodletting, where the doctor cut the veins of the patient to let "bad blood" escape. In some cases the best outcome you could expect was that the "cure" would not kill you. It was not until the latter part of the 1800s that researchers began to understand how to deal effectively with illness and disease.[30]

In the earliest years of the country, and in the parts of the country that were not yet settled, people cared for their sick at home. If a doctor was needed, he would come on horseback or by buggy, sometimes staying overnight. As time went on, some doctors began to board a few of the sickest patients in the doctor's own home. As demand grew, religious and other nonprofit organizations built better facilities and hired additional physicians. Hospitals as we know them today began to emerge in most of the country in the early to mid–1800s, a bit earlier than the voluntary and non–profit old–age homes. Some early hospitals included care for the elderly as a part of their mission, even building "homes" attached to the hospital where the poor elderly could live.[31]

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[29] Stevenson, "History of Long–Term Care."

[30] Ibid.

[31] Ibid.

Unlike the younger, healthier patients, poorhouse patients tended to have chronic conditions that required long–term care. People who were not poor cared for the chronically ill at home. Those who were poor and ill, many of whom were also elderly, often ended up in hospitals for very long periods of time. [32]

A small number of the non–indigent frail elderly people lived in early proprietary, privately–owned facilities called rest houses. Convalescent homes, or medical boarding houses generally rented rooms in a family home.[33]

Hundreds of huge voluntary and non–profit old–age homes were built in the late 1800s and early 1900s, many set on large pieces of property with farms or gardens to help support the residents of the home. As their populations grew, they added additional buildings, like hospitals, barns, and homes for some of the staff. Some became small cities in themselves.[34]

The number of people living to old age and the number of years they spent in old age continued to increase. The average life expectancy at birth increased by 10 years from 1900 to 1930 and increased by another 15 years from 1930 to 1990. This change occurred largely because fewer people were dying in childhood, so a larger percentage of the population lived to old age.[35]

In 1900, those hardy souls who outlived diseases and injury in childhood and early adulthood had nearly as many years ahead of them as today's seniors do and finding a place where they could live for what might be a fairly lengthy period of time was just as

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[32] Ibid.

[33] Ibid.

[34] Ibid,

[35] Ibid.

important then as it is now. People who reached age 65 in 1900 could expect to live another 10–12 years. Those that reached the age of 85 could expect to live another 4–5 years. To underscore the fact that the elderly of this period could live a very long time, an 1898 magazine article names hundreds of people who lived to the age of 100 or older, including a man alleged to be the oldest person in the United States—a pauper who died in a North Carolina almshouse in the summer of 1896 at the reputed age of 128 years.[36]

Urbanization created more problems for elderly at the same time, the United States had become an urban society. At the start of the twentieth century, forty percent of the population lived in the cities, and by the end of the century over seventy-five percent of the population was city–dwellers. Some of these people were coming from the rural areas and others from the flood of immigrants entering the country for the first time. This had an impact on the care of older family members. The cost of maintaining an aged relative in a rural area is so small as to seem an insignificant burden. In the crowded tenement houses of modern cities the situation is very different. Here, as industry is now organized, there is little for an aged person to do. The positions for which men or women over sixty– five years of age were suited for were few. There were always an excess of old men and women looking for such positions. Furthermore, the cost of maintaining an aged relative in the city is an appreciable item in a wage earner's budget and even when the burden is cheerfully borne; it meant that there was less for other necessary family expenditures.[37]

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[36] Ibid.

[37] Ibid.

The structure and size of families was changing. City families were much smaller than country families. In the country, a large family was an economic asset, but city children were economic liabilities. They had to be housed and supported, but could not contribute to the support of the family for many years. It was not economical to have a lot of children, and the shrinking size of families would continue to have an impact far into the future, when fewer children would be available to provide for their aging parents.[38]

Around the turn of the century, tuberculosis or "consumption," the "White Plague" of the eighteenth and nineteenth centuries, became epidemic. Tuberculosis was highly contagious and spread rapidly in the newly–urban society because so many people were living crowed together in cities. Since the disease was so contagious, patients had to be separated from the general population, preferably out in the country where they could get plenty of fresh air, which was believed to be a necessary part of curing the disease.[39]

The spread of tuberculosis was instrumental in spurring the development of public institutions designed to provide chronic care, since patients needed to be maintained for a fairly long period of recuperation. To effectively control the disease, even those who could not pay for their care had to be removed from the general population and cared for at the expense of governments or charities. A large percentage of these patients were indigent. For instance, it was estimated that eighty-five percent of those stricken with tuberculosis in Michigan were unable to pay for their own care.[40]

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[38] Ibid.

[39] Ibid.

[40] Ibid.

Prior to the Great Depression, the only form of public support available for the destitute elderly was institutional. In the American system, the state generally assumed responsibility for the institutional housing of the mental ill, the blind, and the other categories of "deserving poor," which included the retarded, the chronically ill, and the feeble elderly. These individuals remained wards of the counties or municipalities, housed in county "homes "or "farms" at local expense.[41]

Family life and working conditions drastically changed during the Great Depression. Nearly half of the working age population became unemployed in some parts of the country. Even young, healthy people lost their jobs and watched their savings dry up. President Roosevelt quickly initiated numerous Federal Emergency Relief Act (FERA) programs after his election and his Committee on Economic Security estimated that by the end of 1934 there were 750,000 single persons and 4.2 million families receiving some assistance.[42]

The problems hit the elderly particularly hard. Those who were retired or close to retirement, watched a lifetime of savings disappear. Some were not well enough to work or could not find the jobs that would allow them to rebuild their lost investments. That made many of the elderly completely dependent on their families, but hard times for younger family members often meant little or nothing left to provide for their parents.[43]

The Committee on Economic Security reported to President Roosevelt in 1935 that one–third to one–half of the 7.5 million people age 65 or older in the country were

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[41] Bruce Vladick, *Unloving Care: The Nursing Home Tragedy; a Twentieth Century Funding Story* (New York: Basic Books Inc, 1980), 33.

[42] Stevenson, "History of Long–Term Care."

[43] Ibid.

dependent on either public assistance or help from their families. In addition the committee reported that only a relatively small percentage of that group were receiving any help from the government.[44]

By 1935, a majority of legislators agreed that a federal program for old–age pensions and welfare was required, to help the individuals in need. The legislators decided that there was a need to stimulate the depressed economy by getting cash into the hands of citizens, and to retire older workers without impoverishing them in order to make their jobs available to younger people.[45]

The Social Security Act created the National Old–Age Assistance Title I in 1935. The Social Security Act established a program, called Old Age Assistance (OAA), which would give cash payments to poor elderly people, regardless of their work record. OAA provided for a federal match of state old–age assistance expenditures. Among other things, OAA is important in the history of long term care because it later spawned the Medicaid program, which has become the primary funding source for long–term care today.[46]

As the need for nursing care arose among the residents to the homes for the aged and boarding homes, many of these facilities added nursing staff and gradually evolved into nursing homes or personal care homes with infirmaries. The real boost of these settings came with the passage of the Social Security Act in 1935.[47]

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[44] Ibid.

[45] Ibid.

[46] Ibid.

[47] David Burton, *The Growth of Nursing Home Care* (Lexington, KY: Lexington Books, 1979), 100.

One of the big debates in the development of the Social Security Act legislation was how to provide assistance to the poor elderly while getting rid of the poorhouse system that had become so problematic. The National Advisory Council was quite sure they did not want to encourage care in the poorhouses. One way to do that was to give individuals cash payments, which they called "pensions," that would hopefully allow the recipients to remain in their own homes.[48]

Old folk's homes present a traditional and popular escape for some, but are altogether unacceptable for sound psychological reasons to many. Institutional care will always be needed for some proportion of the aged. This may be easily admitted in the case of those who are incapacitated either physically or mentally, but may be optional with healthy old men and women, depending upon their comparative sense of gregariousness. On the other hand the public poorhouse will be condemned by most and, in fact, has been one of the most potent factors in popularizing better methods of provision.[49]

The prohibition of care in public institutions did have an effect on the use of poorhouses. Many of the poorhouses and poor farms saw their population dwindle sharply after 1935. Following a pattern that was repeated throughout the country, fifteen Minnesota poor farms closed between 1935 and 1950.[50]

Although some potential poorhouse residents may have been able to remain at home, that did not solve the problems for everyone. The payments were not generous and

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[48] Stevenson, "History of Long-Term Care."

[49] Ibid.

[50] Ibid.

some recipients needed to find shared quarters in order to get by. Others needed a level of care or supervision that they could not get at home. They could not go to a poorhouse without losing their benefits, but they did have some money to pay for their care. Most of the nonprofit old age homes restricted access to members of their own organizations and, since they were dependent on donations and contributions for survival, they had a limited ability to expand quickly. That left proprietary nursing homes as the only facilities with an unlimited potential to grow to fill the emerging need. As a result, the number of for–profit facilities began to quickly multiply after the Social Security Act became effective.[51]

The contemporary nursing home has come to serve not only the poor and disabled who are without resources of their own, now served others. Formerly individuals served by acute care hospital, mental institutions and other group quarters were being served by nursing homes.[52]

The 1.4 million individuals living in nursing home represent a marked increase over past numbers. By some estimates, the number of nursing home beds doubled between 1963–1973. Today there are two to three times more nursing homes than general hospitals and consequently, more patients' beds, and patients' days in nursing homes than in hospitals.[53]

In contrast, while the nursing home industry was becoming primarily a for–profit industry, hospitals continued to develop under government and non–profit sponsorship.

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[51] Ibid.

[52] Johnson, *The Nursing Home in American Society,* 10.

[53] Ibid., 3.

By 1935, there were about 6,400 hospitals in the United States and virtually all were either non–profit or government facilities. Most hospitals had always admitted a significant percentage of "charity" patients who could not pay their own way, whose care was heavily subsidized by the government or by the religious or charitable institutions that supported the hospitals. They also required more capital and operated on a scale that few private operators would have been able to finance.[54]

The size of the elderly and disabled population was growing and many of them were now eligible for government payments of one kind or another, including veterans benefits, old–age assistance, Social Security, and unemployment assistance. Many of those payments could be used to pay for nursing home care, further encouraging the development of care facilities.[55]

A 1948 Social Security Advisory Council report suggested that additional Old Age Assistance (OAA) payments should be made available for poor people who required medical care. The payments received by the poor were not sufficent to cover medical care.[56]

Care for aged and chronically ill persons is a growing problem and in the opinion of the Council is a Federal concern. Today more than 350,000 recipients of old–age assistance are bedridden or are so infirm as to require considerable help in eating, dressing, and getting about indoors. Of them, about 50,000 are living in commercial boarding or nursing homes or private institutions. Some of these persons living in such

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[54] Stevenson, "History of Long–Term Care."

[55] Ibid.

[56] Ibid.

homes or institutions are getting unsatisfactory care. Of those living in their own homes or with others, many need prolonged treatment in medical institutions.[57]

Nursing homes were emerging all over the country, but there were no federal standards for their design or operation. They were not licensed, buildings were unsafe, there were allegations of abuse and neglect, and nursing care was sometimes non–existent. Most states licensed hospitals, because the Hill–Burton Act required it, but few licensed nursing homes. The 1950 Social Security Act amendments for the first time demanded that states that received federal matching funds must create systems to license both nursing homes and hospitals. This provision was added to "raise the standards of those institutions that have been understaffed and underfinanced, that have been firetraps, and in which people have been badly treated." Effective in 1953, there was a state plan for old–age assistance, aid to the blind, or aid to the permanently and totally disabled which provided payments to individuals in private or public institutions, but the state had to have a state authority to establish and maintain standards for such institutions."[58]

Another important aspect of the 1950 amendments to the Social Security Act was that federal matching funds were finally made available for the cost of providing for aged and blind persons in "public medical institutions other than those for mental disease and tuberculosis." This allowed governments to develop nursing homes, long after proprietary operators had dominated the market.[59]

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[57] Ibid.

[58] Ibid.

[59] Ibid.

Nursing homes have rarely been addressed as a policy problem in themselves, instead today's nursing homes have evolved out of several different types of custodial care facilities, most of which were originally designed to serve the poor. As stated earlier local government took responsibility for the poor.[60]

The traditional role of the county poor farm had become increasingly irrelevant since the inception of Social Security and Old Age Assistance in 1935, although a certain number of poor elderly still remained as the responsibility of the counties. Many of the poorhouses closed or were sold, but a few continued to operate as homes for the indigent elderly. The 1935 law created financial problems for the counties running nursing homes, because the residents could not qualify for Social Security Old Age Assistance. In some cases, the 1950 Amendments created a new source of financing for both the operations and the cost of constructing or renovating buildings to meet new licensing standards, and the county poor farm became a nursing home. In other places, the tougher licensing standards were the last straw and the county poor houses were shut down.[61]

A consensus was building that facilities for the aged should focus on providing medical care, as well as residential care, and legislators decided to actively promote the development of skilled nursing homes. In 1954 the Hill–Burton Act was amended to provide funds to nonprofit organizations for the construction of skilled nursing facilities that met certain hospital–like building standards, if built "in conjunction with a hospital."[62]

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[60] Johnson, *The Nursing Home in American Society,* 5.

[61] Stevenson, "History of Long–Term Care."

[62] Ibid.

The government was totally enmeshed in the business of providing nursing home care by the end of the decade. Various studies in the 1950s found that about half of the residents in private nursing homes were public assistance recipients and that the federal, state, and local governments were paying about half the total cost of all nursing home care in the country. Federal and state reimbursement for the cost of nursing home care continued to increase throughout the decade.[63]

A 1953–54 survey of nursing homes found that 90 percent of the patients in proprietary nursing homes were aged 65 or over. Two–thirds of the aged patients were women. Only one–half could walk alone and one–fifth was completely bedfast. Public assistance financed, in whole or in part, the cost of care of one–half of all patients in proprietary nursing homes. Stated another way: "The proprietary nursing homes of the United States are almost exclusively geared to caring for old people and to a great extent to old people on public–assistance.[64]

By the 1950s, the intent of policymakers to destroy the hated almshouse had clearly succeeded. Most poorhouses had disappeared from the landscape, unable to survive once their inmates no longer received federal annuities. As a result, and due to the lobbying of public hospital associations, Congress amended Social Security to allow federal support to individuals in public facilities. New legislation, including with the Medical Facilities Survey and Construction Act of 1954, allowed for the development of public institutions for needy older adults. For the first time, both public and private nursing–home residents were granted federal support for their assistance. As Homer

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[63] Ibid.

[64] Ibid.

Folks had predicted, not all elderly individuals could be supported in their own homes with monthly pensions; many incapacitated older adults required long–term care.[65]

In 1956, amendments to the Social Security Act created a new, and separate, matching program for medical services like nursing home services, a program which would prove to be far more expensive than first anticipated. In 1958, Federal grants to the states for public assistance were further liberalized. Up to that time, all grants were split 50/50 with the state paying half and the federal government paying half. In 1958, the amount the government provided was based on the per capita income in the state, so that the federal government paid more than half of the cost of OAA in the poor states, and continued to pay half of the cost in richer states.[66]

Not surprisingly, with government financial faucet open wide and few restrictions on what nursing homes should look like or how they should operate, quality issues started to come to the forefront. Among other problems, the lack of standards and the old age of many of the converted buildings made nursing homes fire hazards. When they did burn, there were often many deaths because they were filled with frail elderly residents who were unable to get themselves out of danger.[67]

The existing nursing home industry is almost entirely a public policy and is funded and regulated by the United States government. Two–thirds of the total revenue of the nursing home comes from the government. The explosive growth in the number and

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[65] Carole Haber and Brian Gratton, "Nursing Homes: History," (2008), available at http://medicine.Jrank.org /1243/Nursing-Homes-History.html accessed February 7, 2008

[66] Stevenson, "History of Long-Term Care."

[67] Ibid.

capacity of nursing homes over the past fifteen years has prompted increased public funds. Nursing homes are among the most closely regulated of all institutions.[68]

Nursing home quality concerns escalate, and questions about nursing home quality continued to dominate. By 1960 a U.S. Senate Special Committee on Aging report said that forty-four percent of nursing home beds failed to meet Hill–Burton fire and health standards. This should not have been surprising because few had been held to those standards or any standard when they were built. One reason for concerns about quality was due to fatal nursing home fires, which were becoming all too common. There had been a huge debate about what costs should be covered by Medicare. Nursing home costs were deliberately carved out of Medicare because of a fear that nursing home care would be a bottomless pit that would financially devastate the program.[69]

In 1965, the passage of Medicare and Medicaid provided additional impetus to the growth of the nursing–home industry. Between 1960 and 1976, the number of nursing homes grew by 140 percent, nursing–home beds increased by 302 percent, and the revenues received by the industry rose 2,000 percent. To a great extent, this growth was stimulated by private industry. By 1979, despite the ability of government homes to provide care, 79 percent of all institutionalized elderly persons resided in commercially run homes.[70]

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[68] Karen Buhler–Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore, MD: Johns Hopkins University Press, 2001), 4.

[69] Stevenson, "History of Long–Term Care."

[70] Haber and Gratton, "Nursing Homes: History."

According to investigations of the industry in the 1970s, many of these institutions provided substandard care. Lacking the required medical care, food, and attendants, they were labeled "warehouses" for the old and "junkyards" for the dying by numerous critics. The majority of them, proclaimed Representative David Pryor in his attempt to initiate legislative reform in 1970, were "halfway houses between society and the cemetery." And, like the almshouses of old, people feared ending their days in the wards of these institutions and relatives felt guilty for abandoning their elders to nursing–home care.[71]

The development of the modern–day industry reflects its historical roots. In establishing monthly annuities for the old and disqualifying all residents of public institutions, the creators of Social Security took direct aim at the despised poorhouse. In their initial policies, New Dealers were anxious to sever the connection between old age and pauperism. In barring all residents of public institutions from receiving pensions, however, they clearly underestimated the proportion of elderly persons who required residential support. As a result, they did not initially provide for public asylums or regulate the quality of private care. Although recent legislation has attempted to control nursing homes and federal funds such as Medicaid which contribute to their assistance, the problems that face long–term care for older adults are clearly tied to their historical development. In shutting the almshouse door, policymakers gave birth to the modern nursing–home industry.[72] Medicaid provides coverage for nursing home care. The question about how long term care services would be covered by the federal government

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[71] Ibid.

[72] Ibid.

was answered by requiring the states to provide both medical home health and nursing home services to their poor elderly in order to receive a federal match for the costs of their Medicaid program. States also could optionally include people who did not qualify as "poor" based on their income or assets if they could not afford to pay for the medical care they needed (the medically–needy), so long as the recipients "spent down" their assets to pay for as much as they could before receiving Medicaid payments.[73]

Another event that occurred in 1965 was the passage of the Older Americans Act. This Act created the Administration on Aging; authorized grants to states for aging–related community planning, services programs, research, demonstration, and training projects; and called for the development of State Units on Aging. This created what is now called the "Aging Network," a web of federal, state, and local agencies linked together to focus on social services and other programs primarily targeted to older adults living in their homes. The mission of the Aging Network was expanded in numerous ways in subsequent years, to include advocacy, meal programs, and a number of other services. Because of a lack of funding, many of the services developed long waiting lists, which limited the benefits to a relatively small proportion of the poorest elderly. Although the program had the potential to save the government money by providing more supportive services to people who wanted to remain in the community as a substitute for some of the nursing home costs, it never had the visibility or legislative urgency of Medicare and Medicaid.[74]

The problem of caring for the weak and sick members of society has always been with us. Living longer is a good thing. Medical progress has made it possible for people

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[73] Stevenson, "History of Long–Term Care."

[74] Ibid.

to live longer, however, older people must contend with living in a fast–paced busy culture that is not designed for those who are chronically ill, weak, or disabled.[75]

Experts agree that the number of younger disabled persons has grown in recent years and this trend may well persist as new technologies and increased access to medical care continues to enable more people to survive injuries and other conditions that were fatal, and thus to live for many years with limitations.[76]

One of the challenges facing the United States in the 21st Century will be to ensure that individuals throughout their life will have the support they need and will be treated with dignity. For the growing population of the elderly and people with disabilities, ensuring the adequacy and availability of direct care workers is one solution to meeting this ideal. As this report shows, the aging "baby boomer generation" will be the most significant factor increasing the demand for long–term care services over the next half century. The number of individuals using nursing facilities, alternative residential care, or home care services is expected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be driven by the growth in the number of elderly in need of such care, which is expected to double from approximately 8 million in 2000 to 19 million in 2050.[77]

America is facing a critical shortage of competent and compassionate caregivers. Right now about 40 percent of people over sixty, and 1.9 million paid caregivers share the burden of providing home care for older or disabled Americans. This does not take

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[75] Lynn Dickinson and Xenia Vosen, *Living Well in a Nursing Home: Everything You and Your Folks Need to Know* (Almaeda, CA: Hunter House Publishers Inc, 2006), 43.

[76] Binstock, *The Future of Long–Term Care*, 8.

[77] Robert N. Butler, "Who Will Care for You?," *AARP Bulletin* (2007), 41.

into account the significant number of people who go completely without the help they need.[78]

This problem will worsen in the next few years. Within twenty years, one–fifth of all Americans will celebrate their 65th birthday. Older people today are healthier than in the past and are living longer. It has been reported that more than one–third are living with a disability severe enough to require assistance and that assistance is typically provided by a family member. Many of the baby boomers will likely require caregivers both for their parents and eventually for themselves. By 2030 the United States will need between 5.7 and 6.6 million caregivers.[79]

The situation is grave because as a nation there has been little attention paid to the problem dealing with the aging, chronically ill, and disabled. At one time elderly persons were honored and respected and their wisdom was considered valuable. However, that is no longer true in America. Youth is valued and the culture is oriented to youthful interest.[80] The nation has been focusing on youth. Most of the marketing and businesses are focused on and to the young and the able. Even the church has given most of its attention to those who are young, healthy, working, and active.

In this section the focus has been on the history of care to the chronically ill and disabled by the family and the transition of long–term care to facilities out of the family home to nursing homes. For clarity of the terms used in this section, "long– term care" and "nursing home" will be defined.

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[78] Ibid.

[79] Ibid.

[80] James Montgomery Boice, *Psalms Volume 2, Psalms 42-106* (Grand Rapids, MI: Baker Books, 1996), 593.

Long–term care means regular assistance with medical care (nursing, medicating, physical therapy, or personal needs such as eating, dressing, bathing, or moving around) provided by someone outside an older person's family. There are many varieties of long–term facilities ranging from part–time home care, adult daycare, independent living, assisted living residential communities, and nursing home facilities. Sometime the long–term care is temporary because the individuals are recovering from a broken hip or a stroke.[81]

A nursing home is a long–term care facility and is defined as a place of residence for people who require constant nursing care and have significant deficiencies with activities of daily living and chronic medical problems. Most residents of nursing homes are elderly; however, some are young rehabilitating from an accident.[82]

There are 18,000 nursing homes in the United States and about 1.6 million people living in nursing homes. More than ninety percent of current residents are sixty-five years of age and over, with half being eighty-five years or over. The average age upon admission is seventy-nine. Women are almost three times as likely to live in a nursing home as men.[83]

The church has had a significant part in the care of the chronically ill and disabled even though very little has been said to distinguish the church from the rest of the community. The role of the Black church in particular has promoted the health and well–

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[81] Joseph L. Matthews, *Beat the Nursing Home Trap: A Consumer's Guide to Assisted Living and Long–Term Care* (Berkley, CA: Nolo Press, 1999), 1-4.

[82] Ibid., 4-5.

[83] U. S. Center for Disease Control and Prevention, National Center for Home Statistics, *Nursing Home Care* 2006, available at http://www.cdc.gov/nchs/fastats/nursingh.htm, accessed March 11, 2007.

being of Blacks. Historically the Black church has been the single most important institution embodying the goals and purposes that pertain to the welfare of Black people.

The caring practices of the church reflect the view that all persons are persons of worth. Caring means showing concern for self–esteem, self–worth, and well–being by treating people with honor and respect. The church seeks ways within the congregation and outside the faith community to reach people in crisis to give hope, where there is anger, fear, pain, and depression. Caring practices are those intentional efforts of the Black church to create a space in which faith and healing can connect.[84]

Modern elder–care facilities have come a long way in providing clean, attractive environments where the elderly can live out their sunset years with dignity and in relative comfort. Most quality nursing homes strive to care not only for their residents' physical needs, but also to offer recreational and learning opportunities—everything from exercise classes to pet therapy. Still, nursing home staff may not have the time to provide the conversation and companionship that the residents need.[85]

In summary it has been shown how the events and decisions have affected the care for the chronically ill and disabled in the United States over the past two hundred years. A review of the past events, services and programs will help design and develop better services in the future for residents in nursing homes.

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[84] Ronald Braithwaite, *Health Issues in the Black Community* (San Francisco, CA: Jossey–Bass Publishers, 2001), 137.

[85] Roberta Rand, "A Friend in the Winter: Ministering to the Elderly in Nursing Homes," (2006), available at http://www.family.org/socialissues/A000001274.cfm, accessed March 11, 2007

Biblical Foundations for Ministry

Old Testament Scripture

The Old Testament Biblical foundation text for this project is an exegesis of Psalms 71:9 as it relates to the elderly in nursing homes. In Psalm 71:9 the psalmist prays and calls out to God "Do not cast me away when I am old; do not forsake me when my strength is gone."[86] This is the also the cry of the elderly and residents in nursing homes. In order to get an understanding of this text, it is important to do a background study.

The Psalms are an important resource for spirituality and have been so for generations.[87] The book of Psalms is a collection of prayers, praises, and worship to God by various psalmists. According to Walter Brueggemann, the book of Psalms provides the most reliable theological, pastoral, and liturgical resource given to us in the biblical tradition. Faithful women and men turn to the Psalms as a helpful resource for conversation with God about things that matter most.[88] The psalmists cried out to God from the depth of despair and they praise God in the height of celebration. Whether despairing or rejoicing the psalmist share honest feelings with and about God.[89]

Walter Brueggeman says that the Psalms do not reflect the common, everyday kind of conversation that makes life sound agreeable and pleasant. The Psalms are

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[86] Psalm 71:9 New International Version (NIV), unless otherwise noted, all Scripture references are taken from the New International Version.

[87] Walter Brueggemann, *The Message of the Psalms* (Minneapolis, MN: Augsburg, 1984),168.

[88] Ibid., 15.

[89] Ronald A Beers, ed., *Life Application Bible* (Wheaton, IL: Tyndale House Publishers, 1988), 815.

different in their "tell it like it is" approach. According to Brueggemann, people only become truly eloquent and passionate in their prayers to God.[90] The voices of the Psalms are human beings who know and understand how chaotic life can be, yet confidently affirm that God does not abandon the living to their sorrow but delivers them out of the pit and redirects their lives.[91]

The great theologian, John Calvin, pens the memorable statement, which he repeats in the preface to his commentary: the Psalms are "an anatomy of all feeling of the soul." All emotions of the human heart, joy, anger, temptation and sorrow can be found in the Psalms. They teach us how necessary it is to call on God's help when we encounter trials.[92]

The Bible speaks of old age with honor and respect. The experience of life as some believe makes old age, a sign of maturity and wisdom. The Bible also speaks of old age as a time of weakness. There are many vivid descriptions of old age as being a time when limbs will tremble, one will have only a few teeth, and eyesight becomes dim or even blind.

Three of the major chronic diseases affecting family members during Bible times were leprosy, blindness, and lameness. The Israelites had compassion for the blind. Jesus ministered to many people who were blind. Many people were afflicted with leprosy, which was a chronic infectious disease characterized by sores and scabs on the skin. Leprosy was a disease that was feared at that time just as the fear of getting cancer is

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[90] Pamela S. Hart, "The Psalms as a Resource for Nursing Home Ministry," *Journey of Religious Gerontology* Vol 12, no 2 (2001), 62.

[91] Ibid., 64.

[92] Herman J. Selderhuis, *Calvin's Theology of the Psalms* (Grand Rapids, MI: Baker Academic, 2007), 23.

today. Lameness was disability in one or more limbs especially in a foot or leg, so that a person would experience difficulty in walking or moving freely.[93]

Life expectancy was difficult to determine in the biblical times. In Genesis some lived to be over 900 years while others lived shorter periods of time, and in Psalm 90:10 it stated that "The length of our days is seventy years or eighty, if we have the strength."

The Psalms of "lament," are a model of Godly response to suffering. God does not expect us to remain stoic through our suffering. We can pour out our hearts, and souls. However, we must remember God's loving care for us in the past; how He led us out of the captivity of sin, forgave our sins, brought us into His Church, and gave us eternal life. Knowing all this, one can willingly trust Him with the future. In the Psalms, one can hear the strong, emotional words of sufferers. These are words written by real people, in very difficult situations. These Godly sufferers know that God will not be angry with their honesty, for even when they scream at God, it is a scream of faith.[94]

The Psalms of lament follow a basic structure. There is an introductory cry such as "help me; I am hurting and the enemy is winning." There is introduction to pain and hurt being experienced. The writer addresses God directly seeking attention to his plight and informing God of the enemy. There is usually a confession of trust and a reason for God to act. Expressions such as "hear me or save me" are common. Then the writer vows to praise God.[95]

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[93] Ibid., 303.

[94] "Construction of the Psalms: A Bible Study," available at http://www.biblesudy.org/basicart/psalm–construction.html. accessed February 7, 2008

[95] Ibid.

Psalm 71, is a Psalm of "lament," with a major focus on the writer's trust in God. The Psalm alternates between expressions of desperate need and resolute trust in the Lord.[96] The author of Psalms 71 is an unknown believer who has a need. He is probably past middle age and was greatly concerned about the burdens of old age.[97] It is apparent that the psalmist knows that the Lord gives help to those who call on him and trust him. The Psalmist remembers God's faithfulness and that God has been with him. He trusted God not to abandon him in his old age.[98]

In Psalm 71, verses 1–3, there is a confession of trust in God. The prayer opens with a note of trust. The worshipper has sought and found refuge with God in his sanctuary and has thus reached a position which fills him with confidence and trust that enables him to pray that God may hear and rescue him, that He may deliver him from the persecution of his ungodly and violent adversaries. Before he utters his second supplication, the worshipper once more reverts to the position of trust from which he started, going far back to his early youth.[99]

The theme of this psalm is God's constant help from childhood to old age. God is faithful. The writer does not indicate that he is physically ill, but is probably emotionally stressed and fearful. The Psalmist had to come to grips with the truth and consequences of aging. He is an old man now stripped of his confidence, weak and frail. He feels defenseless and afraid. He realized that in old age, he was no longer able to defend

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[96] Ibid.

[97] Warren Wiersbe, *Be Worshipful* (Colorado Springs, CO: Cook Communications Ministries, 2004), 230.

[98] Ibid., 231.

[99] Artus Weiser, *The Psalms: A Commentary* (Philadelphia, PA: The Westminster Press, 1962), 498.

himself against an enemy. His only chance of enduring a crisis was to turn to God for help. He had to reaffirm his faith and plead to God not to abandon him in the same way that society had treated him. His words express his insecurity, fear, and frustration.[100]

In verses 4–6, the psalmist asks God to deliver him from the hand of the wicked, the unrighteous and cruel men. The Psalmist laments and cries to the Lord for rescue. He is stressing that he trusts and hopes in the Lord alone, and all through his life he trusts and looks to the Lord for divine salvation.[101]

Sometimes during trials and tribulations, we must cry out to God for strength and support to get through that period of time. Believers have learned that God answers prayers and He draws near when we call upon Him.

In verses 7–8, the poet says that he was a wonder to many. The word, "wonder," is defined by Strong's Concordance as a sign or miracle.[102] The poet says that God is his strong refuge. The word, "refuge," is defined as a shelter against harm and a place of hope.[103] The poet states in Psalms 71, verse 8, that his mouth is filled with praise and declares God's glory and splendor all day long.

In verse 9 the psalmist says "Do not cast me away when I am old; do not forsake me when my strength is gone" Strong defines the word "cast" as throw out, down or

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[100] Rachel Zohar Dulin, *A Crown of Glory: A Biblical View of Aging* (New York: Paulist Press, 1988), 50.

[101] John Eaton, *The Psalms a Historical and Spiritual Commentary with an Introduction and New Translation* (New York: Continuum, 2005), 257.

[102] James Strong, *The New Strong's Exhaustive Concordance of the Bible* (Nashville, TN: Thomas Nelson Publishers, 1990), 1229.

[103] Ibid., 65.

away.[104] The psalmist did not want to be abandoned by God. The Living Bible paraphrases the scripture as "don't set me aside in my old age."[105] The word "forsake" is defined as leave or refuse. The dictionary also defines forsake as abandon.[106] Abandon suggest that the person is left helpless without protection. Some residents feel abandoned by their family, friends and the church when they do not hear from or receive visits from people who have been a part of their circle of relationships. The Psalmist is saying do not leave or refuse me when my strength is gone. The Psalmist looked to God for care, protection, and deliverance. Old age has not dried up the spring of his hope nor weakened his religious spirit.[107]

Our bodies and minds become slower in responding as we age and the energy and vitality that we had in our youth begins to fade. We need help as we grow older and we need to call upon the Lord for help because He says to call upon Him in the time of trouble. God is our source of help and care. No one wants to be forgotten whether they are young or old. God is always faithful and He never forgets His children. In this Psalm, the psalmist wanted to remind God that he trusted and had faith in God since his youth. Paraphrased, this periscope says, "You will not cast me off in my old age, or forsake me when my strength fails. God's faithfulness in his youth gave him confidence in old age. God never forsakes His own."[108]

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[104] Ibid., 117.

[105] Beers, *Life Application Bible*, 867.

[106] *Webster Ninth New Collegiate Dictionary* (Springfield, MA: Merriam-Webster Inc. 1983), 43.

[107] *The Interpreter's Bible, Volume IV* (Nashville, TN, Abingdon Press, 1955), 372.

[108] Finis J. Dake, *Dake's Annotated Reference Bible* (Lawrenceville, GA: Dake Bible Sales Inc, 1963), 580.

New Testament Scripture

Nursing homes serve individuals who are disabled and chronically ill and those who are unable to care for themselves. During Bible times there were many disabled, invalids, and chronically ill individuals. The care of the sick and disabled was provided for by the family. Many of the chronically sick, disabled, and frail elderly did not live long. The ones who did live long sometimes gathered in public places with other disabled and chronically ill individuals.

The New Testament Biblical foundation text is the Gospel of John 5:2–9. In the opening of the gospel of John, chapter five, the Bible describes that there was a feast in Jerusalem and the city was more crowded than usual at this festive time and there was attention directed at the multitude.[109] Jesus enters the city of Jerusalem in verse one. In verse two, there is a detailed description of the setting in Jerusalem.[110] There was a body of water known as the Pool called Bethesda. The difference in the place named for the pool is the results of variants in the textual tradition.[111] The name Bethesda meant a "house of mercy." The pool of Bethesda was a long rectangular pool used to clean animals about to be taken to the temple for sacrifice. The water was two to three feet deep.[112] This pool was near the Sheep Gate where a great number of disabled people lie about, sheltered by five covered colonnades used in part to protect them from the weather. Underground springs were the source of water for the pool. Beneath the pool

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[109] Everett Harrison, *John the Gospel of Faith* (Chicago, IL: Moody Press, 1962), 36.

[110] *New Interpreter's Bible*, Volume IX (Nashville, TN, Abingdon Press, 1995), 578.

[111] Ibid.

[112] Elmer Towns, *The Gospel of John: Believe and Live* (Old Tappan, NJ: Fleming H. Revell Company, 1990), 110.

was a subterranean stream which every now and again bubbled up and disturbed the water. In verse four, it is stated that at certain times the angel came down and stirred the water. The belief was that the disturbance was caused by an angel and that the first person to get into the pool after the troubling of the water would be healed from any illness from which he was suffering. This kind of belief was spread all over the world in ancient days and still exists in certain places.[113] Ancient people were impressed with the holiness of water and especially of rivers and springs. Water was so precious and rivers could be so powerful that it is not surprising that they were so impressed.[114] The presence of disabled and invalids at the pool stemmed from the belief that the person who first touched the stirred waters would be healed. Pools of water were figurative of God's blessings.[115]

Healing shrines were common throughout the ancient world. Most of the shrines required individuals to purify themselves at the adjourning fountain or other source of water. [116]

Today people still try to find places where they can get physically healing. Some travel long distances to visit healers or places where they heard that people experienced healing, just as those who sat around the pool of Bethesda. It is believed that the disabled gathered at the pool because they had hope, and to talk to other disabled.

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[113] William L Barclay, *Gospel of John* (Philadelphia, PA: Westminster Press, 1975), 178.

[114] Ibid.

[115] Herbert S. Lockyer, *Nelson's Illustrated Bible Dictionary* (Nashville, TN: Thomas Nelson Publishers, 1986), 860.

[116] Craig S. Keener, *IVP Bible Background Commentary* (Downers Grove, IL: InterVarsity Press, 1993), 275.

In this Bible passage, Jesus went to Jerusalem during a feast, not to maintain a religious tradition, but to heal a man. This miracle was not only a demonstration of his ability to heal, but a message to the people. John describes the people at the pool as impotent, blind, lame, and paralyzed. The healing of these infirmities was one of the prophesized ministries of the Messiah.[117]

The Bible describes a certain man, which had an infirmity for thirty–eight years was at the Pool of Bethesda in John 5:5. The length of time is mentioned in order to highlight the seriousness of the ailment and the hopeless condition of the man.[118] Jesus knew that the man had been sick a long time and caught sight of him among the many others but saw him in the depth of his misery.[119] This man had been sick there longer than many people in antiquity lived and almost as long as the children of Israel had wandered in the wilderness. Ancient reports of healing often specified how long the person had been sick to emphasize the greatness of the healer's cure.[120]

Jesus' question to the invalid indicated that for thirty-eight years, the man was disabled. The question provided an opportunity for the man to paint a picture of his condition and his thoughts. The disabled man was lonely and helpless, yet hopeful for healing. This man had some faith otherwise he would not have come daily to the pool, but he made an excuse as some people do when they need help. Sometime when there is a

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[117] Warren W. Wiersbe, *Be Alive* (Wheaton, IL: Victor Books Publishing, 1986), 59.

[118] John Ridderbos, *Gospel of John: A Theological Commentary* (Grand Rapids MI: William B. Eerdmans Publishing Company, 1997), 184.

[119] Ibid., 186.

[120] Keener, *IVP Bible Background Commentary,* 275.

long wait in answer to prayer, discouragement grows and with it unbelief develops.[121] Although the invalid did not see how he could be healed without someone's help, his response to Jesus was immediate because he had a desire to be healed and his conversation with Jesus must have inspired him with faith to respond to Jesus' command to rise, take up your bed, and walk.[122]

Many of the residents in nursing homes are lonely, helpless, and somewhat hopeful for healing. Waiting has that effect on those who are suffering with illness. Discouragement and unbelief begins to develop after a long period of waiting.[123] Having lost hope, some individuals prefer their present condition. These sick and infirm people sometimes prefer to remain in their sick state since it wins them sympathy and aid.[124] The problem is exacerbated by circumstances that put seniors in care facilities far removed from immediate family. Isolated from loved ones, many retreat into dreams of the past, simply waiting to die.[125]

The Theological Foundation for Ministry

The theological foundation for this project is pastoral theology. Pastoral theology is a practical application of the Scriptures to the relationship between a minister of the Gospel and the people for whose spiritual well–being he is responsible. It is theology

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[121] Towns, *The Gospel of John*, 111.

[122] Barclay, *Gospel of* John, 179.

[123] Towns, *The Gospel of* John, 111.

[124] Harrison, *John the Gospel of Faith,* 37.

[125] Stevenson, "History of Long–Term Care."

because it deals with the things of God and His Word. It is pastoral, because it relates to a pastor and his people.[126]

The importance of this branch of theology is recognized by every denomination in the Christian Church; and every training college for ministers has a department of pastoral or practical theology. The emphasis is on the character of the pastor and the care of souls. This care is exercised in different ways, such as the visitation of homes for the discussion of spiritual problems or personal interviews.[127]

At one point pastoral care was mainly a matter of instructing those training for ministry in the skills and aptitudes that were needed for practical tasks such as visiting people in their homes. Pastoral care has become more sophisticated because people who are not committed to any religious belief take courses in universities, colleges, and seminaries.[128]

According to Dan Browning, a professor at University of Chicago, the desire to care for another person, whether it comes from a minister or a secular therapist, presupposes certain attitudes of a religious kind. Deciding to care for another person assumes certain convictions that that person is worth valuing and caring for, not just for certain instrumented purposes, but intrinsically and with regard to some wide standard of

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[126] James D. Douglas, *The New International Dictionary of the Christian Church* (Grand Rapids, MI: Zondervan Publishing House, 1978), 751.

[127] Ibid., 751.

[128] James Woodward and Stephen Pattison, *The Blackwell Reader in Pastoral and Practical Theology* (Malden, MA: Blackwell Publishing, 2000), xiii.

value and worth.[129] Browning argued the case for pastoral theology being understood as a "practical theology of care."[130]

Ed Wimberly believes that stories function in the caring setting to bring healing and wholeness to the lives of persons and families within the Black pastoral care context.[131] Edward Wimberly's book, *African American Pastoral Care,* was written for the clergy and lay on how to care for one another and how care can be improved. The book demonstrated an indigenous approach to caring which relies upon storytelling as a style of pastoral care and counseling that takes place in the Black Church.[132]

This section will show how the life and work of the Apostle Paul, a pastor in the early church, demonstrated care and compassion for the people of God and how he was comforted during times of distress.

The early church established a caring community that shared their possessions to help meet each other's needs. When the increase in the size of the church made it impossible for the apostles to care for the needy in a fair and equitable manner, deacons were chosen for the task of caring for the widow. Paul states the principle of a caring community in Galatians by saying, "Therefore as we have opportunity let us do good to all people, especially to those who belong to the family of believers" [133]

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[129] Ibid., 94.

[130] Ibid., 89.

[131] Edward P. Wimberly, *African American Pastoral Care* (Nashville, TN: Abingdon Press, 1991), 11.

[132] Ibid., 10.

[133] Galatians 6:10

According to the conventions of friendship in that society, Paul and the Thessalonians were obligated not only to comfort each other in distress, but also to remember each other and to recall the comfort which each brings to the others as well.[134] The root meaning of the word comfort is "with strength."[135] The ministry of comfort requires that a shepherd get close enough to the sheep to see the wound and feel the pain.[136]

Abraham Malherbe asserts that consolation "was offered not only at death but on the occasion of all misfortunes that caused grief."[137] For there are definite words of comfort habitually used in dealing with poverty, definite words in dealing with life spent without obtaining office and fame; these are distinctly definite forms of discourse dealing with exile, ruin of country, slavery, infirmity, blindness, every accident upon which the term disaster can be fixed.[138] Death was not the only concern of the ancient consolers. Paul's depiction of his restlessness and resolve to get back to Thessalonica suggest that the separation of whatever type was a mutually heartbreaking experience.[139] Paul offers several consolatory words for why the community should not allow grief to overtake them. One word is that the community must console itself just as it has consoled others.

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[134] Abraham Smith, *Comfort One Another: Reconstructing the Rhetoric and Audiences of I Thessalonians* (Louisville, KY: Westminster John Knox Press, 1995), 53.

[135] David W. Wiersbe, *The Dynamics of Pastoral Care* (Grand Rapids, MI: Baker Books, 1997), 98.

[136] Ibid.

[137] Abraham Malherbe, *Social Aspects of Early Christianity* (Philadelphia, PA: Fortress Press, 1983), 124.

[138] Smith, *Comfort One* Another, 53.

[139] Ibid., 54.

The Thessalonians are admonished to continue to console each other just as they are already.[140]

The aging apostle suffered physical distress. While his first imprisonment in Rome could be described as "house arrest" (Acts 28), and he was given a certain measure of freedom, this period of bondage was quite different. According to tradition, his final imprisonment took place in the "Well–Dungeon" near the capital, a damp and cold vaulted pit. In his letter to Timothy, Paul urges Timothy to bring his cloak (2 Tim. 4:13) and to do his best to come before winter sets in (2 Tim. 4:21).[141]

Though he was aware of the Lord's presence with him, Paul must have experienced times of loneliness. "Only Luke is with me" (2 Tim. 4:11), he wrote.[142] He also encountered great disappointment. Some of the friends he was counting on to testify on his behalf had left. "You know that everyone in the province of Asia has deserted me, including Phygelus and Hermogenes" (2 Tim. 1:15). One of his faithful traveling companions, Demas, also deserted him (2 Tim. 4:10, Col. 4:14, Phlm. 24). "At my first defense, no one came to my support, but everyone deserted me. . ." (2 Tim. 4:16).[143]

During these dark days of loneliness, discomfort, disappointment, and uncertainty, the Lord provided strength and renewal. He did so through His presence, but He also used a man, a man whose name is obscure and difficult for us to pronounce, and who is mentioned briefly only twice in the New Testament. Yet to the Apostle Paul this

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[140] Ibid., 55.

[141] Stephen S. Hopper, "Onesiphorus: A Refresher Course: What did Onesiphorus do that endeared him to the Apostle Paul and Won Him a Place in Scripture," available at http://www.navpress.com/EPubs, accessed December 18, 2007.

[142] Ibid.

[143] Ibid.

man became a dear friend and a choice servant for the Lord. His appreciation for this man overflows into intercession that is unique in Paul's writings: "May the Lord show mercy to the household of Onesiphorus . . ." (2 Tim. 1:16), and again, "May the Lord grant that he will find mercy from the Lord on that day! . . ." (2 Tim 1:18). The ministry of Onesiphorus was a ministry of refreshment. He sought to bring relief from pressures, weariness, loneliness, and discouragement. He provided refreshment to the spirit so that his friend could continue on with new strength and a different perspective. The ministry of refreshment involves genuine concern, willingness to take risks, and persistence in service. It requires being alert to the needs of others and seeking to provide relief from the pressures that burden them.[144]

Suffering comes to all, even to those who live godly. Just as Onesiphorus was a source of comfort to the Apostle Paul, those who minister to residents in nursing homes can be a source of comfort too.

Our world is filled with hurting people who need a loving touch and a word of encouragement. Jesus put His people here to let the world know that He cares.[145] We serve a caring and compassionate God who is working in and through people to accomplished his will on earth by showing care, concern, and compassion to those who are weak, hurting, weary, sick, oppressed, elderly, and those in need. Clearly, God has worked through people to improve the conditions of the sick, disabled, and those in need. Jesus sent out disciples two by two to minister to the needs of the people during his earthly ministry.

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[144] Ibid.

[145] Warren W. Wiersbe, *Be Compassionate* (Colorado Springs, CO: Cook Communications Ministries, 2005), 7.

In the Bible the psalmist David said that God is a gracious and compassionate God and is slow to anger and abounding in love. The Bible states also in Mark 10:45 that Jesus did not come to be served, but to serve. All Christians are called to serve the Lord, the church, each other, and society.[146] Christians have a responsibility to do good deeds by serving others. The ability to offer compassionate care to others comes from our faith in God.[147] Jesus taught that the true measure of greatness is service or ministry. The word "ministry" is defined as a biblical term that means to serve or servant. Service is what Jesus exemplified in his own life and what He expects us to practice in our lives. No matter what our title or position, we are in the church to serve God.[148] The Apostle Paul refers to his work in the service of the gospel and the church as a ministry.

Dr. Luke describes Jesus as one who mingled with people, including publicans and sinners, and who had compassion for the afflicted and the weak.[149] Jesus was concerned about individuals. He preached to great crowds, but His message was always to the individual. He took time to help people personally. His purpose was to transform people and send them out to share His message of love and forgiveness.[150]

The first principle of a compassionate ministry is that it is model on the works of Jesus, a continuation of the ministry of Christ and is enabled by the Spirit of Christ. This

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[146] Michael Green, *Freed to Serve* (Dallas, TX: Word Publishing, 1983), 106.

[147] Judith Allen Shelly, *Spiritual Care: Guide for Caregivers* (Wheaton, IL: InterVarsity Press, 2000), 75.

[148] David Wiersbe, *The Dynamics of Pastoral Care,* 9.

[149] Warren Wiersbe, *Be Compassionate*, 7.

[150] Ibid., 48

means that it is a ministry of testimony to God and loving service to our neighbor that is inspired, guided, and empowered by the Holy Spirit.[151]

The second principle is that this ministry belongs to the whole church and is the calling of each member of the church to serve God. The aim of ministry is the edification and inward renewal of the church and at service of the world in testimony to God and in work for the fulfillment of the divine purpose.[152]

The main purpose of the church is its mission to the world. The laypeople have daily contact with the world outside the church. The mission of the church manifests itself more clearly in the lives of the laypeople because they carry out the mission of the church in the marketplace.[153] The apostle Paul and the early church demonstrated deep concern for those in need.

Compassionate ministry is a response to grace, a participation in grace, and an offer of grace. God's compassion becomes our compassion. It is in this place of compassion where we discover the Christ who is the compassion of God and that we find the strength to share that compassion with others.[154]

Compassion is not one of our most spontaneous and natural inclinations as human beings. Compassion is intentionally entering into community with those who suffer and work on their behalf.[155]

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[151] Owen C. and Ellen K. Wondra Thomas, *Introduction to Theology* (Harrisburg, PA: Morehouse Publishing, 2002), 306.

[152] Ibid.

[153] Ibid.

[154] Bryan P. Stone, *Compassionate Ministry* (Maryknoll, MD: Orbis Books, 1996), 158.

[155] Ibid., 44.

The experience of a compassionate Christian community can provide a creative and liberating channel between the suffering world, on one hand, and our helpless and hopeless individual responses to that suffering, on the other. In the Christian community, the sights and sounds of suffering do not dissipate behind cold stained glass. In the Christian community, we find strength for compassion. Through the bond of the Spirit, we can do far more together than any one or all of us can do individually.[156] An effective compassionate ministry model requires compassionate and caring teams as well as individuals who are committed to serving the hurting with a loving and human touch.

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[156] Ibid., 158.

CHAPTER FOUR

METHODOLOGY

Hypothesis

The hypothesis of this research project is that the training of nursing home volunteers would improve religious services and visitations programs to residents in nursing homes. Training is vital and necessary to become effective in ministry. It is important to provide information and develop skills in individuals who serve the elderly and disabled. Residents in nursing homes require programs that are geared to individuals who are physically and mentally challenged. It was the goal of the writer to collaborate with other ministry leaders, nursing home activity directors, and other professionals who serve the aging to develop a collaborative and effective model for ministry to residents in nursing homes.

Intervention

As stated in Chapter One, the context for this project dissertation is the Women in Ministry Resource Center, located in Mitchellville, Maryland, which is a small town in Prince George's County. The writer is the Program Director of the ministry and is also the Coordinator of Acts of Kindness Senior Assisted Living Ministry at her local church.

In working with the elderly, the writer has recognized a need for a team of trained, caring volunteers to serve residents in nursing homes and other long–term care facilities.

Research Design

The methodology used in this project is a combination of qualitative and quantitative research design, which includes a pre– and post–test and interviews as methods of data collection. The triangulation method uses both questionnaire and interview to validate information.[1] The questionnaire provides a quantitative assessment[2] and was used in this research to reach several populations of people. Written questionnaires access more persons in a shorter period of time; however, the writer recognized the instrument must be carefully structured because questionnaires do not provide the in–depth information that can be obtained in the interview method.[3]

Measurement

The goal of the project was to measure improvement in ministry at nursing homes by providing training to participants who provide services in nursing homes. Ministry teams and other volunteers participated in a training seminar. As a part of the training, participants were given information and resources to improve and update their knowledge and skills in serving residents in nursing homes. Further information and details will be described in Chapter Five.

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[1] Jean McNiff, Pamela Lomax, and Jack Whitehead, *You and Your Action Research Project,* 2nd ed. (London: Routledge Falmer, 2003), 100.

[2] William R. Myers, *Research in Ministry: A Primer for the Doctor of Ministry Program*, 3rd ed. (Chicago, IL: Exploration Press, 2002), 55.

[3] Ibid., 61.

Instrumentation

The writer selected three data collection instruments for this research project. The results and analysis of this study are in Chapter Five. This section introduces the data collection instruments.

Observation was the first qualitative instrument for collection of data in this research project. The writer observed the worship services and activities of volunteers in nursing home for eighteen months.

The second instrument used was interviewing. Interviews were conducted with current and former staff working in nursing homes, staff in departments of aging in the county and state government, and ministry leaders of nursing home ministries.

The third data collection instrument used was comprised of a quantitative instrument which included a survey/questionnaire. Two different sets of questionnaires were designed. One set was mailed to activity directors who were staff employees at local nursing homes. A second set of questionnaires were mailed to families who had family members who were residents in nursing homes. A pre–test and a post–test were administered to nursing home volunteers who participated in a training workshop for ministry teams and volunteers.

CHAPTER FIVE

FIELD EXPERIENCE

Designing the Research Project

The purpose of the research project was to develop a collaborative ministry model for the residents in nursing homes. The hypothesis of this research project is that the training of nursing home volunteers would improve religious services and visitation programs in nursing homes. The research design was developed as a result of observations, interviews, and collaboration with clergy, nursing home team leaders, nursing home staff, nursing home residents, and family members of residents in nursing homes. Based on the information received during the observations, the writer determined there was a need for training and innovative programs.

Observations

Observations were made at several nursing homes in Prince George's County, Maryland. The four nursing homes included in this project were the Manor Care Health Services in Largo, Maryland, Clinton Nursing and Rehabilitation Center in Clinton, Maryland, Gladys Spellman Specialty Hospital and Nursing Center in Cheverly, Maryland, and Crescent Cities Center in Riverdale, Maryland. Observations were made as a participant observer. The writer observed the environment, atmosphere, the activities

of the staff, activities of the residents, and ministry leaders during services being conducted at the nursing home.

The writer visited and observed the atmosphere in several nursing homes over the last eighteen months. The atmosphere in most of the nursing homes was quiet and somber. The buildings were well kept and neatly decorated. The staff at the nursing homes were pleasant, polite, and helpful.

Some of the residents in nursing homes had a sad countenance; however, most were quiet. Some residents appeared to be sedated. The nursing staff wheeled residents into meeting rooms to participate in worship services provided by the local ministry team. The writer and ministry team usually opened the service with prayer. Some of the residents sang along with ministry team, while others just sat quietly, and some made noises. After participating for several months, the writer recognized the services were boring and some of residents were there just to be a part of a religious program. The writer began to bring music on compact disc in an effort to improve the worship service. There was an immediate change in the response of the residents. Some of the residents began to respond in a very positive way, which included patting their feet, clapping hands, and waking up.

The writer observed two residents on a one–to–one visitation in two nursing homes. The two individuals were permanent residents of the nursing homes due to immobility and a lack of care at home. The writer visited the residents on several occasions. These residents were bedridden and usually did not attend religious programs or services. One of the residents watches some religious programs on television in her room. During a recent visit, the writer discovered that the resident's television did not

work and the resident could not received telephone calls because the phone was inoperable. This resident was a female and she was neatly dressed in gown and wore lipstick and nail polish. On one visit, the resident asked the writer to bring some food on the next visit. The writer brought fruit and fried chicken because the resident did not like the food served by the facility. Permission was given to bring food to the resident. The families of some residents do not visit regularly and this particular resident was referred to the writer by another minister. This particular resident had been bedridden and had not been out the bed for a year when the writer began to visit. The resident was fearful of falling and did not want to move out of the bed. A minister and the writer began to pray for the resident and within a week's time the resident allowed the attendant to put her in a wheel chair and she went outside her bedroom for the first time in over a year.

The writer visited another resident in the Manor Care Health Services. This resident was forty-nine year old single female who was placed in the nursing home after treatment of cancer. She was pleasant and looked forward to going home. She did not have family members to provide the kind of care she need. This resident asked the writer to bring some snack food on subsequent visits. The writer brought snacks on two occasions. This resident attended the same church as the writer and had attended a toastmaster meeting for several months.

Interviews

Interviews were conducted with three ministry leaders of three different denominations. The interviews were conducted between February and October 2007. Two of the interviewees were lay leaders, one Baptist, and the other Catholic. The third

ministry leader interviewed by the writer was a member of the clergy. The writer served on the ministry team with the clergy at Manor Care.

Four questions were posed to the interviewees. The questions were as follows:

1. Tell me what services you provide to residents in nursing homes.
2. How often do you visit nursing homes?
3. How many volunteers participate with you during visits?
4. Is training provided for volunteers and what type?

The persons being interviewed gave the following responses. The Baptist ministry lay person involved provided the following information. The ministry team is composed of six to fifteen people who participate in monthly visits to the nursing homes. This ministry team conducts traditional worship services, Bible Study and one–to–one visits. There is no formal training provided to volunteers. Volunteers learn by observation and participation. This nursing home ministry has special holiday programs during the year, such as Christmas parties. The ministry publishes a newsletter to keep the volunteers and churches informed of nursing home ministry activities. The newsletter is used as means of recruiting volunteers.

The Catholic layperson was a part of the Legion of Mary. This ministry provided weekly one–to–one visitation to residents in nursing homes on Saturday. The visitation teams were composed of two people who visit individual residents. The team rotated every week so every resident gets a visit. There was no formal training. The volunteers learned by observing team leaders.

The last person interviewed was an ordained Pentecostal minister who was the team leader for ministry to Manor Care. The interviewee stated that her ministry provided a monthly worship service to residents at the nursing home. The worship service had

some structure, but was informal with no standard program. The ministry team provided one–on–one visits to members of the church. The ministry was composed of twenty volunteers with seven to ten participating on a regular basis. The ministry team leader had training as a chaplain; however, the volunteers did not receive any formal training. There were two deacons who received leadership training in the local church. One volunteer had taken a visitation course offered at the church's Bible School. The interviewee indicated that her ministry team provided services to residents with dementia; however, there were no special programming planned.

Survey

Two surveys were sent out in the Fall of 2007 to activity directors in nursing homes and families who have family members in nursing homes. The purpose of the survey that was sent to nursing home staff was to determine the types of programs being conducted by churches/ministries in nursing homes and how the staff and residents viewed the programs and services. Seventeen nursing homes were contacted and fourteen agreed to participate. Nine completed surveys were returned and evaluated (see Appendix A).

Fourteen surveys were sent to family members who had relatives in nursing homes. The writer sent surveys to families because the nursing homes do not allow outside visitors to interview residents. Eleven completed surveys were returned and analyzed (see Appendix B). The purpose of this questionnaire was to find out the perceptions of residents regarding religious services at the nursing home.

Pre– and Post–Test

A questionnaire was developed to determine the perceptions toward ministry training and what types of religious services are being conducted for residents in nursing homes. A pre–test was distributed to 17 participants at the beginning of a training seminar conducted in October 2007 (see Appendix C).

Implementing the Research Project

A training seminar was designed to provide formal training to ministry leaders and volunteers who serve in nursing homes. The seminar was designed with information from research studies, literature on aging, and other sources gathered from agencies and individuals who have done training to those who do visitation in nursing homes and hospitals. The title of the seminar was "Improving Ministry to Residents in Nursing Homes." The seminar was advertised to volunteers and others who work with residents. The seminar was conducted on a Saturday. Participants signed in on a registration form. A pre–test and handouts were distributed to all participants. The writer conducted the seminar with the assistance of volunteers from Women in Ministry.

An outline and summary of the training seminar included facts about the aging process and ministry to residents. Most people become more spiritual as they grow older. There is a spiritual side that needs to be addressed for it is more important than the physical side of life. Residents need fellowship with other saints. The nursing home ministry is equipped to meet the spiritual needs of residents through visitation, worship services, and one–on–one visits. Visitation, worship services, and other spiritual programs increase and sustain faith and assurance in God's grace and love. The need to

love and be loved grows keener with age. Love has been shown to increase an individual's desire to live longer. Residents who are believers in Christ do not lose heart when they see the decay of the outer man or physical body because by God's grace. The inner man is being renewed day by day. The aging process functions in the life of the believer to wean away from the temporal things of life to eternity.

The second area covered dealt with training volunteers to serve in long–term care facilities. Each volunteer should have an orientation to nursing home ministry, which includes a discussion of issues relating to aging in order to gain an understanding of the elderly.

An orientation to the church's overall program should be offered to new volunteers. Information should be provided about specific tasks or duties required by volunteers. Information on what is expected of volunteers and commitment of time to the ministry should be given when the volunteer begins to serve. Volunteers should be informed of problems that may occur during visits to nursing homes. Literature about the particular nursing home and information on where to park should also be provided.

The third area covered involved establishing a caring team that collaborates together. Ministry teams and volunteers should get together as a team to pray for guidance and directions. Volunteers should be friendly and somewhat outgoing, making patients comfortable and committed to regular visitation.

The fourth area covered was facts about the twenty licensed nursing homes in Prince George's County, Maryland.

Evaluating the Research Project

In this section the writer will provide an evaluation and analysis of the surveys. The results of the survey sent to nursing home staff members are detailed in Appendix D.

Question one asked respondents to describe their position in the nursing home. This question was addressed to persons who schedule churches or ministries for religious services in nursing homes. The activity directors are the first people who arrange for churches to conduct religious services in the nursing home. Eight out nine respondents were activity directors, and one manager completed the survey.

Question two asked the respondent how often do churches conduct services at your nursing home. This question was designed to determine how frequently religious services were provided at nursing homes. Seven out of nine responded that churches conducted services weekly, one out of nine answered that churches conducted services bi–weekly and one of nine responded that churches conducted services twice a week.

Question three asked the respondent to describe the type of services provided by churches or ministries. This question was designed to determine the types of religious services and programs conducted by churches at nursing homes. Six of nine indicated that traditional worship services, Bible Studies, musical programs, and one-to-one visits were conducted. Two out nine indicated that churches provided traditional worship services, Bible study, musical programs, one-to-one visits, and dance and music programs; One out of nine indicated traditional worship, Bible Study, musical program one-to one visits and dance and drama. Some of the respondents provided more than one response because music, liturgical dance and drama are included in traditional worship programs.

Question four asked the respondent how many churches conduct services on a monthly basis. This question was designed to determine how many churches are conducting services monthly. The results indicated that five to ten churches conduct services monthly by five out of nine respondents, one out of nine respondents said sixteen or more churches conducted services on a monthly basis, two out of nine answered that eleven to fifteen churches conducted services each month, and one out of nine answered that sixteen or more churches conducted services monthly.

Question five asked the respondent to describe responses to services by churches or ministries. This question was designed to discover the perceptions of how residents respond to religious services conducted at the nursing home. All nine responded that residents look forward to worship services and took an active part in services. Three out of those nine also said residents expressed interest in different types of services and six out of nine indicated that residents liked seeing people from the church. One out of nine indicated that residents would like more music or choirs.

Question six asked about the denominational preferences. This question was designed to determine the denominations that conduct services at nursing homes. Findings indicated several denominations were listed as preferences. Four out of nine indicated Baptist, Methodist, and Catholic as preferences. Three out of nine indicated Baptist, Catholic, and African Methodist. Two out nine indicated Pentecostal and Lutheran, and two out nine indicated Pentecostal and Jehovah Witness.

A survey was sent to the family of those who had family members in nursing homes. A summary of the results and findings are stated in the following paragraph (see Appendix E).

Question one asked what the relationship was to the Nursing Home resident. This question was designed to determine the relationship of the resident in the nursing home. Four out of eleven respondents indicated that they were children of the resident, two out of eleven were sister/brother/ nephew or cousin, two out of eleven were in-laws, and one was a spouse.

Question two asked the respondent to describe the frequency of their visits to the family member in the Nursing Home. This question was designed to determine the frequently with which family members visit residents. Seven out of eleven said they visited weekly, two out of eleven said monthly, and two out of eleven said they visit occasionally or seldom.

Question three asked the respondent to describe the resident's spiritual background. This question was designed to gain information about the resident's spiritual background. Five out of eleven indicated that the resident actively served in church, three out of eleven indicated that the resident attended church regularly; one out of eleven said their relative did not attend church, and one respondent was not sure about the resident's spiritual life.

Question four asked the respondent to describe the resident's interest in worship services at the nursing home. This question was asked to gain information about resident's interest in religious services being offered by the church in the nursing home. Four out of eleven of the respondents indicated that the resident takes part in worship services. Five out of eleven residents would like to have one–on–one visits by the church and one resident indicated interest in a different kind of religious program, one

respondent answered that the resident had no interest in worship services at the nursing home.

Question five asked the respondent to describe the denominational preference of the resident. This purpose of this question was to determine if denomination mattered. Four out of eleven respondents indicated that residents prefer Baptist, two out eleven prefer Catholic, two out of eleven Pentecostal, two out of eleven were not sure and one preferred Lutheran.

Question six asked the respondent to describe the visitation activities of churches to your family member or friend in the nursing home. The purpose of this question was designed to determine the type of visits made by churches to the residents. Three out of eleven respondents indicated that a church group did visit and conduct worship services. Three out of eleven respondents indicated that individuals from the church did visit residents and three indicated that a pastor or minister did visit the resident. Only one respondent indicated that there were no visits from the church, and one respondent was not sure about visits.

Pre– and Post–Test Results

A pre– and post–test was distributed to 18 participants attending a training seminar and was completed by seventeen participants. The pre– and post–test consisted of sixteen questions. The outcome and analysis of the pre– and post–test is indicated in the following summary (see Appendices F and G).

Questions one, two and three asked gender, age range, and educational level of the participant. This question was designed to gain information about the participants. Four males and fourteen females participated in the training and seventeen completed

pre– and post–tests. All participants were over thirty–six. Thirteen out of seventeen were over fifty–six years old and eleven out of seventeen were college graduates. One has a Master of Divinity and another participant was working on a Doctorate.

Question four asked how long the individual has been involved with the nursing home ministry. This question was designed to determine how long participants had been involved in nursing home ministry. It was discovered that twelve out of seventeen had been involved in the nursing home ministry for more than five years. Three out of seventeen participants had been in nursing home ministry for less than a year, and two did not answer.

Question five asked how many volunteers are on a ministry team or come with a team to the nursing home. This question was designed to find out how many volunteers are visiting nursing homes. Two out seventeen stated that there were one to two on their team, four out of seventeen participants indicated that there were three to five on their ministry team, four out of seventeen participants indicated that there were six to nine on their ministry team, two out of eleven indicated that there were ten or more on their ministry team, three out of eleven indicated that they came alone to visit at nursing homes, three did not answer.

Question six asked how often the ministry teams meet to discuss new programs or strategies for ministering to residents in the nursing homes. This question was designed to determine if volunteers are meeting to plan programs and services to nursing homes. Most teams do not meet often; however, two out of seventeen participants answered that they meet monthly and two out of seventeen stated that they meet semi–annually, ten

out of seventeen participants did not answer, two out seventeen do not know if they meet, one participant indicated that they do not meet.

Question seven asked how often worship services/programs are conducted at the nursing home. The purpose of this question was to determine how often ministries conduct services in nursing homes. Most teams provide services to nursing homes monthly. Nine of seventeen meet monthly to conduct worship services, two out of seventeen meet weekly to conduct worship services, three out seventeen indicated other without an explanation, and three participants gave no answer.

Question eight asked what type of worship services/programs are provided at the nursing home. This question was designed to gain information on what types of services are provided by ministry teams. Ten participants indicated that they conduct traditional worship services. Six participants indicated that they do one–to–one visits.

Question nine asked participants to describe the type of training provided by the ministry. This question was designed to gain information on what type of training is provided by the ministry. Seven out of seventeen participants indicated that they received training in a seminar or workshop, three out of seventeen indicated that receive training on site or by watching others, one out of seventeen received Pastoral Care for the Elderly (CPE) video training , two out of seventeen participants said they received no training, and four out of seventeen did not answer.

Question ten asked the reason for serving in nursing home ministry. This question was designed to gain information on the reason for serving in nursing home ministry. Five out of seventeen participants indicated that they served in nursing ministry because they have a ministry calling; one out of seventeen was invited by a church leader or

friend. Two participants were concerned about the elderly, had a ministry calling and had another reason for serving in nursing homes. Five out of seventeen gave no answer. One out of seventeen participants answered that they were concerned about the elderly; one out of seventeen participants was invited by a friend or indicated other as the answer.

Question eleven asked is it important for volunteers to be caring and compassionate. This question was designed to determine perceptions about whether it is important to be caring and compassionate. Thirteen out seventeen strongly agreed that ministry volunteers should be caring, one out seventeen agreed that volunteers should be caring, and one strongly disagreed on the pre– test, however on the post test all seventeen participants strongly agreed that it was important for volunteers to be caring and compassionate.

Question twelve asked if volunteers should be well–informed about ministry to the elderly and disabled. This question was designed to gain information on the need to be informed about residents being served. On the pre–test, eight out of seventeen strongly agreed that volunteers should be well–informed about the elderly and disabled, six out seventeen agreed about being well informed and one out of seventeen strongly disagreed that volunteers should be well- informed. On the post–test, fourteen out of seventeen strongly agreed, and two agreed that volunteer should be well-informed.

Question thirteen asked if the ministry team should meet and pray before entering and conducting worship services/programs. This question was designed to see if teams get together before meeting with residents. In the pre test eight of seventeen participants strongly agreed that volunteers should meet and pray before entering to conduct services in a nursing home, six out seventeen agreed that volunteers should meet and pray, one out

of seventeen strongly disagreed and there two out of seventeen who did not answer. Thirteen out of seventeen strongly agreed in the post–test, and five of seventeen agreed.

Question fourteen asked if the program and ministry activities should be planned in advance by the ministry team. This question was designed to find out if teams planned out programs. Seven participants out of seventeen strongly agreed, and six out of seventeen agreed, one out of seventeen strongly disagreed that ministry activities should be planned in advanced in the pre–test and eight out of seventeen participants strongly agreed; seven out seventeen agreed that ministry activities should be planned out in the post–test.

Question fifteen asked if worship services/programs should be designed and planned to meet the spiritual needs of the elderly and disabled. The purpose of this question was designed to determine if services were developed to reach residents who have limitation in hearing, seeing, and understanding. Twelve out of seventeen participants strongly agreed, and three out of seventeen agreed in the pre–test that worship services should be planned to meet the spiritual needs of the elderly and disabled. However, only ten out of seventeen strongly agreed, and six out of seventeen agreed in the post–test that worship services should be planned to meet the special needs.

Question sixteen asked if those who perform worship services in Nursing Home Ministries should receive some training. This question was designed to gain information on the perceptions toward understanding the need for training. Eleven out of seventeen participants in the pre–test strongly agreed, and five out of seventeen agreed that volunteers should receive training, and thirteen out of seventeen in the post–test strongly

agreed that participants should receive training, and four out of seventeen agreed that participants should receive training.

The findings show that the perceptions toward ministering to the elderly improved as a result of participation in the training seminar.

CHAPTER SIX

REFLECTION, SUMMARY, AND CONCLUSIONS

The purpose of this research project was to develop a collaborative ministry model to improve worship services and visitation programs to residents in local nursing homes. The results of the research and data collected support the hypothesis. The writer believes that the research is beneficial to those who provide religious services to residents in nursing homes. The results of the research indicate the church is very active in serving residents in nursing homes locally and nationally. Every nursing home contacted in the county indicated that churches were providing worship services weekly or monthly. In fact nursing home staff are asking churches and ministries for special activities for the residents other than the tradition or routine type worship services. This is an opportunity for the church to be a light in the world and to develop relationships with staff and families of residents which may lead to an opening for evangelism.

The writer would recommend that individuals who conduct services in nursing homes should provide regular training sessions to volunteers every year. There should be an orientation for new volunteers with some information on what to expect and do at nursing homes. In addition the writer plans to develop and publish a handbook/manual for volunteers who serve in nursing homes.

The writer found that the interviewing process provided the most useful information and valuable insights into how people think about serving and actually how

they do ministry. The interviewing process takes time; however, the writer believes that the relationships were built and information acquired was beneficial to the improvement in ministry.

The writer recommends that ministry should be tailored to the group being served. The traditional worship services do not always meet the needs of individuals with limitations. Some ministries are resistant to change and remain committed to tradition although it may be ineffective. Churches and ministries must be flexible and open to making changes to meet the need of residents

During the research process, the writer discovered that almost all the people she encountered indicated that they had a relative, a friend, or knew someone in a nursing home. The writer has determined from research studies, population trends, and medical advancement that many will live their lives in institutionalized facilities.

There is a great need for more personal or individual meeting with residents. One of the activity directors sent a note attached to her completed survey indicating a need for more one–on–one visits. This activity director indicated that she receives numerous responses from family members' churches. She has turned down requests for routine services. The activity director said residents like spiritual groups. The writer would recommend that ministry leaders talk with activity director to find out what type of religious program and activity are needed and develop a service or program with the residents' special needs or interest in mind.

The church must begin to encourage volunteers to do personal visits because that is where the greatest need is. The writer would urge volunteers to plan and commit time in visiting individuals. Volunteers can plan to spend thirty additional minutes after the

regular program or service to visit one individual resident. There are some residents who are unable to attend any group worship service due to the severity of the physical conditions.

In conclusion, the research was beneficial to the volunteers in the Women in Ministry Resource Center, Ridgley Church of God in Christ Nursing Home Ministry team. The writer plans to provide the results of the research to those ministries who have been in collaboration with the Women the Ministry Resource Center.

APPENDIX A

QUESTIONNAIRE TO NURSING HOME STAFF

APPENDIX A

QUESTIONNAIRE TO NURSING HOME STAFF

The Purpose of this questionnaire is to determine what type of spiritual programs are being conducted by churches and ministries in Nursing Homes in Prince George's County, and how the programs are viewed by staff and residents.

Please complete the following questions by placing a (√) next to the answer that best describes your view.

1. Describe your position in Nursing Home.

   _____Administrator
   _____Activity Director
   _____Nursing Staff
   _____Other

2. How often do churches or ministries conduct services at your Nursing Home?

   _____Weekly
   _____Bi-Weekly
   _____Monthly
   _____Other

3. Describe the type of service provided by churches or ministries.

   _____Traditional worship service
   _____Bible Study
   _____Musical Program
   _____Dance/Drama
   _____One to One Visitation
   _____Other_____

4. How many churches or ministries conduct services on a monthly basis?

   _____1-5
   _____5-10
   _____11-15
   _____16+

5. Describe the resident's response to services provided by churches or ministries.

_____Residents look forward to the worship services
_____Residents take active part in the services
_____Residents express interest in different types of services
_____Residents like seeing people from Church
_____Residents would like more one-to-one visits
_____Not Sure of Residents interest
_____Other_____

6. Describe the denomination preference of residents.

_____Baptist
_____Methodist
_____Catholic
_____Africa Methodist
_____Pentecostal
_____No preference
_____Not Sure
_____Other_____

APPENDIX B

QUESTIONNAIRE TO FAMILY MEMBERS OF RESIDENTS

APPENDIX B

QUESTIONNAIRE TO FAMILY MEMBERS OF RESIDENTS

The Purpose of this questionnaire is to determine if the families of Nursing Home residents feel that the Church is meeting the spiritual needs of family members.

1. What is your relationship to Nursing Home resident?

   ____Child of resident
   ____Sister/Brother/Niece/Nephew/Cousin
   ____Spouse
   ____In-Laws
   ____Friend
   ____Other _____

2. Describe the frequency of your visits to family member or friend in Nursing Home.

   ____Weekly
   ____Monthly
   ____Occasionally
   ____Seldom

3. Describe resident's spiritual background

   _____Actively served in Church
   _____Attended Church regularly
   _____Not Active in Church
   _____Did not attend Church
   _____Not sure
   _____Other_____

4. Describe resident's interest in Worship Services at Nursing Home

   _____Resident talks about worship services
   _____Resident talks about other religious program
   _____Resident takes part in worship services
   _____Resident would like one-on-one visit by church
   _____Resident is not interested in spiritual or religious activities
   _____Don't know

5. Describe the denominational preference of resident.

_____Baptist
_____Methodist
_____Catholic
_____African Methodist
_____Pentecostal
_____No Preference
_____Not sure
_____Other_____

6. Describe visitation activities of churches to your family member or friend in nursing homes.

_____Church groups visited and conducted worship services
_____Individuals from church visited my family member/friend
_____Pastor/Minister visited my family member/friend
_____Not sure about visits
_____No visits for local church
_____Other_____

APPENDIX C

PRE– AND POST–TEST QUESTIONNAIRE TO MINISTRY TEAMS

APPENDIX C

PRE– AND POST–TEST QUESTIONNAIRE TO MINISTRY TEAMS

The purpose of this questionnaire is to determine what types of ministry (worship services or programs) are being conducted at nursing homes in Prince George's County, Maryland.

PART I
Please complete the following questions by placing a (√) next to the answer that best describes your view

1. Gender: Male_____ Female_____

2. Age:

   18-25 _____
   26-35 _____
   36-45 _____
   46-55 _____
   56 + _____

3. Education Level

   Did not complete High School _____
   High School Graduate/GED _____
   College Graduate _____
   Bible School _____
   Other _____ _____

4. How long have you been involved with the Nursing Home Ministry?

   0-1 year _____
   1-3 years _____
   3-5 years _____
   5+ years _____

5. How many volunteers are on your ministry team or come with you to nursing home?

   1-2 _____
   3-5 _____
   6-9 _____
   10+ _____
   I come alone _____

6. How often do the ministry teams meet to discuss new programs or strategies for ministering to residents in nursing homes?

Monthly_____
Quarterly _____
Semi-annually _____
Yearly _____
Don't Know _____
Don't meet _____
Other_____ _____

7. How often do you conduct worship services/programs at Nursing Homes?

Weekly _____
Bi-Weekly _____
Monthly _____
Other _____

8. What type of Worship Services/Programs do you provide at the Nursing Home?

Traditional Worship _____
Bible Study _____
Praise Team _____
Sing-along _____
One-to-One Visits _____
Drama/Illustrate Sermon _____
Dance _____
Other _____ _____

9. Describe the Type of Training provided by ministry.

No training _____
On-site/Watching others _____
Video training _____
Instruction Book _____
Seminar/Workshop _____
Other_____ _____

10. Reason for serving in nursing home ministry

____ Invited by a church leader
____ Invited by friend in the Nursing Home Ministry
____ Concerned about the elderly and disabled
____ Have a Family Member in Nursing Home
____ Ministry Calling
____ Other _____

PART II
Answer the following questions by circling the answers that best express your level of agreement or disagreement using the following choices

Strongly agree Agree Disagree Strongly Disagree

11. It is important that the ministry volunteers be caring and compassionate

Strongly Agree Agree Disagree Strongly Disagree

12. Volunteers should be well-informed about ministry to the elderly and disabled

Strongly Agree Agree Disagree Strongly Disagree

13. The ministry team should meet and pray before entering and conducting worship service or program

Strongly Agree Agree Disagree Strongly Disagree

14. Programs and ministry activities should be planned in advance by the ministry team

Strongly Agree Agree Disagree Strongly Disagree

15. Worship Services/Programs should be designed and planned to meet the spiritual needs of the elderly and disabled.

Strongly Agree Agree Disagree Strongly Disagree

16. Those who perform worship services in Nursing Home Ministries should receive some training?

Strongly Agree Agree Disagree Strongly Disagree

APPENDIX D

RESULTS OF NURSING STAFF QUESTIONNAIRE

APPENDIX D

RESULTS OF NURSING STAFF QUESTIONNAIRE

The Purpose of this questionnaire is to determine what type of spiritual programs are being conducted by churches and ministries in Nursing Homes in Prince George's County, and how the programs are viewed by staff and residents.

Please complete the following questions by placing a (√) next to the answer that best describes your view.

1. Describe your position in Nursing Home.

   Administrator _____
   Activity Director __8__
   Nursing Staff _____
   Other ___1_____

2. How often do churches or ministries conduct services at your Nursing Home?

   Weekly __7__
   Bi-Weekly __1__
   Monthly _____
   Other twice a week __1__

3. Describe the type of service provided by churches or ministries.

   Traditional worship service __9__
   Bible Study __9__
   Musical Program __7__
   Dance/Drama __3__
   One to One Visitation __7__
   Other_____ __1__

4. How many churches or ministries conduct services on a monthly basis?

   1-5 __1__
   5-10 __5__
   11-15 __2__
   16+ __1__

5. Describe the resident's response to services provided by churches or ministries.

__9__ Residents look forward to the worship services
__9__ Residents take active part in the services
__3__ Residents express interest in different types of services
_____ Residents like seeing people from Church
_____ Residents would like more one-to-one visits
_____ Not Sure of Residents interest
__1__ Other would like more music/choirs

6. Describe the denomination preference of residents.

__7__ Baptist
__4__ Methodist
__7__ Catholic
__3__ Africa Methodist
__2__ Pentecostal
_____ No preference
_____ Not Sure
__2__ Other Lutheran/Jehovah Witnesss

APPENDIX E

RESULTS OF FAMILY MEMBERS QUESTIONNAIRE

APPENDIX E

RESULTS OF FAMILY MEMBERS QUESTIONNAIRE

The Purpose of this questionnaire is to determine if the families of Nursing Home residents feel that the Church is meeting the spiritual needs of family members.

1. What is your relationship to Nursing Home resident?

_4_ Child of resident
_2_ Sister/Brother/Niece / nephew/Cousin
_1_ Spouse
_2_ In-Laws
____ Friend
_2_ Other _____

2. Describe the frequency of your visits to family member or friend in Nursing Home.

_7_ Weekly
_2_ Monthly
_1_ Occasionally
_1_ Seldom

3. Describe resident's spiritual background

_5_ Actively served in Church
_3_ Attended Church regularly
_2_ Not Active in Church
_1_ Did not attend Church
____ Not sure
_1_ Other _____

4. Describe resident's interest in Worship Services at Nursing Home

____ Resident talks about worship services
_1_ Resident talks about other religious program
_4_ Resident takes part in worship services
_5_ Resident would like one-on-one visit by church
____ Resident is not interested in spiritual or religious activities
_1_ Don't know

5. Describe the denominational preference of resident

__4__ Baptist
_____ Methodist
__2__ Catholic
_____ African Methodist
__2__ Pentecostal
_____ No Preference
__2__ Not sure
__1__ Other __Lutheran_____

6. Describe visitation activities of churches to your family member or friend in nursing homes.

__3____ Church groups visited and conducted worship services
__3____ Individuals from church visited my family member/friend
__3____ Pastor/Minister visited my family member/friend
__1____ not sure about visits
__1____ no visits for local church
_____ other_____

APPENDIX F

RESULTS OF PRE–TEST QUESTIONNAIRE TO MINISTRY TEAMS

APPENDIX F

RESULTS OF PRE–TEST QUESTIONNAIRE TO MINISTRY TEAMS

The purpose of this questionnaire is to determine what types of ministry (worship services or programs) are being conducted at nursing homes in Prince George's County, Maryland.

PART I
Please complete the following questions by placing a (√) next to the answer that best describes your view

1. Gender: Males 4 Female 13

2. Age:

18-25	
26-35	
36-45	3
46-55	1
56 +	13

3. Education Level

Did not complete High School	
High School Graduate/GED	3
College Graduate	11
Bible School	1
Other	2

4. How long have you been involved with the Nursing Home Ministry?

0-1 year	3
1-3 years	0
3-5 years	
5+ years	12
No answer	2

5. How many volunteers are on your ministry team or come with you to nursing home?

1-2	1
3-5	4
6-9	4
10+	2
I come alone	3
No answer	3

6. How often do the ministry teams meet to discuss new programs or strategies for ministering to residents in nursing homes?

Monthly	2
Quarterly	
Semi-annually	2
Yearly	
Don't Know	2
Don't meet	1
Other	2
No answer	8

7. How often do you conduct worship services/programs at Nursing Homes?

Weekly	2
Bi-Weekly	
Monthly	9
Other	3

8. What type of Worship Services/ Programs do you provide at the Nursing Home?

Traditional Worship	10
Bible Study	2
Praise Team	4
Sing-along	4
One-to-One Visits	6
Drama/Illustrate Sermon	2
Dance	1
Other	2

9. Describe the Type of Training provided by ministry.

No training	2
On-site/Watching others	3
Video training	2
Instruction Book	
Seminar/Workshop	7
Other No answer	3

10. Reason for serving in nursing home ministry.

2	Invited by a church leader
1	Invited by friend in the Nursing Home Ministry
7	Concerned about the elderly and disabled
2	Have a Family Member in Nursing Home
9	Ministry Calling
3	Other

PART II

Answer the following questions by circling the answers that best express your level of agreement or disagreement using the following choices

Strongly Agree Agree Disagree Strongly Disagree

11. It is important that the ministry volunteers be caring and compassionate

Strongly Agree (13) **Agree** (1) **Disagree** **Strongly Disagree** (1)

12. Volunteers should be well-informed about ministry to the elderly and disabled

Strongly Agree (8) **Agree** (6) **Disagree** **Strongly Disagree** (1)

13. The ministry team should meet and pray before entering and conducting worship service or program

Strongly Agree (8) **Agree** (6) **Disagree** **Strongly Disagree** (1)

14. Programs and ministry activities should be planned in advance by the ministry team

Strongly Agree (7) **Agree** (6) **Disagree** **Strongly Disagree** (1)

15. Worship Services/Programs should be designed and planned to meet the spiritual needs of the elderly and disabled.

Strongly Agree (12) **Agree** (3) **Disagree** **Strongly Disagree**

16. Those who perform worship services in Nursing Home Ministries should receive some training?

Strongly Agree (11) **Agree** (5) **Disagree** **Strongly Disagree**

APPENDIX G

RESULTS OF POST–TEST QUESTIONNAIRE TO MINISTRY TEAMS

APPENDIX G

RESULTS OF POST–TEST QUESTIONNAIRE TO MINISTRY TEAMS

The purpose of this questionnaire is to determine what types of ministry (worship services or programs) are being conducted at nursing homes in Prince George's County, Maryland.

PART I
Please complete the following questions by placing a (√) next to the answer that best describes your view

1. Gender: Males 4 Female 13

2. Age:

18-25	
26-35	
36-45	3
46-55	1
56 +	13

3. Education Level

Did not complete High School	
High School Graduate/GED	3
College Graduate	11
Bible School	1
Other	2

4. How long have you been involved with the Nursing Home Ministry?

0-1 year	3
1-3 years	
3-5 years	
5+ years	12
No answer	2

5. How many volunteers are on your ministry team or come with you to nursing home?

1-2	1
3-5	4
6-9	4
10+	2
I come alone	3
No answer	3

6. How often do the ministry teams meet to discuss new programs or strategies for ministering to residents in nursing homes?

Monthly	2
Quarterly	
Semi-annually	2
Yearly	
Don't Know	2
Don't meet	1
Other	2
No answer	8

7. How often do you conduct worship services/programs at Nursing Homes?

Weekly	2
Bi-Weekly	
Monthly	9
Other	3
No answer	3

8. What type of Worship Services/ Programs do you provide at the Nursing Home?

Traditional Worship	10
Bible Study	2
Praise Team	4
Sing-along	4
One-to-One Visits	6
Drama/Illustrate Sermon	2
Dance	1
Other	2

9. Describe the Type of Training provided by ministry.

No training	2
On-site/Watching others	3
Video training	1
Instruction Book	
Seminar/Workshop	7
Other No answer	3

10. Reason for serving in nursing home ministry

2	Invited by a church leader
1	Invited by friend in the Nursing Home Ministry
7	Concerned about the elderly and disabled
2	Have a Family Member in Nursing Home
9	Ministry Calling
3	Other

PART II

Answer the following questions by circling the answers that best express your level of agreement or disagreement using the following choices

Strongly Agree Agree Disagree Strongly Disagree

11. It is important that the ministry volunteers be caring and compassionate

Strongly Agree (17) **Agree Disagree Strongly Disagree**

12. Volunteers should be well-informed about ministry to the elderly and disabled

Strongly Agree (14) **Agree** (2) **Disagree Strongly Disagree**

13. The ministry team should meet and pray before entering and conducting worship service or program

Strongly Agree (13) **Agree** (5) **Disagree Strongly Disagree**

14. Programs and ministry activities should be planned in advance by the ministry team

Strongly Agree (8) **Agree** (7) **Disagree Strongly Disagree**

15. Worship Services/Programs should be designed and planned to meet the spiritual needs of the elderly and disabled.

Strongly Agree (10) **Agree** (6) **Disagree Strongly Disagree**

16. Those who perform worship services in Nursing Home Ministries should receive some training?

Strongly Agree (13) **Agree** (4) **Disagree Strongly Disagree**

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